

Health and Human Services



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Summary
of Major
Legislation

Senate Bill 21

Relating to health insurance.

SB 21 provides consumer protection standards for managed care enrollees and prospective enrollees. In response to the number of legislative proposals relating to managed health care, the Consumer Standards Work Group was appointed to attain consensus on the issues raised by the measures. The work group was chaired by the director of the Department of Consumer and Business Services (DCBS) and the Oregon Health Plan Administrator. Other members of the work group represented consumers, purchasers, hospitals, health plans, insurers, and health care providers.

SB 21 requires that health plans disclose specific information to enrollees at the time of enrollment, upon their request, and at the time a grievance is filed. The measure requires written policies that recognize enrollee rights to voice grievances, to have information about the organization and its services, to participate in decision-making regarding their health care, and to be treated with respect and recognition of their need for privacy. Insurers are required to have a timely and organized system for resolving grievances and appeals, providing two levels of review and an opportunity for enrollees to appear before the review panel. The measure also requires enrollees be informed of their right to file complaints with DCBS.

The bill requires insurers to provide enrollees, upon their request, a summary of information the insurer may consider in its utilization review of a particular condition or disease (this information shall not amount to advice as to how the insurer would cover or treat that enrollee's particular disease or condition).

The measure requires insurers offering managed health insurance to file an annual summary with DCBS documenting the scope of the insurer's network and the ongoing monitoring to ensure that all covered services are reasonably accessible to enrollees. In addition, insurers are required to provide DCBS with annual summary of grievance and appeals data.

Insurers that conduct utilization review are required to file an annual summary with DCBS describing all utilization review activities. Insurers offering managed health insurance are required to have a quality assessment program and file annual summaries with DCBS that describe quality assessment activities, the insurers health-promotion and disease-prevention activities, the

results of any publicly available Health Care Financing Administration reports, and accreditation surveys by national organizations.

The measure specifies that disclosure of information shall not be required if the information is otherwise confidential under any other provision of law. The measure also requires certain medical services contracts to entitle the party who is being reimbursed for provision of services to a full accounting of certain health benefits claims data.

In addition, SB 21 prohibits termination of providers for communicating with a patient in a manner that is not slanderous, defamatory, or intentionally inaccurate and specifies that clinical decisions regarding length of hospital stays shall be the decision of the provider, in consultation with the patient.

If an insurer has a restrictive drug formulary, the measure requires a written procedure by which a provider may prescribe drugs not on the formulary and a procedure to provide full disclosure to enrollees of any cost-sharing or other requirements to obtain drugs not on the formulary.

The measure specifies that prior authorizations relating to benefit coverage shall be binding on the insurer if obtained no more than 30 days prior to the date of service. Prior authorizations relating to enrollee eligibility shall be binding on the insurer if obtained no more than five business days prior to the date of service.

Under the measure, a Health Care Consumer Protection Advisory Committee with consumer, provider, and insurer representatives will be appointed to advise the director of DCBS regarding implementation of the measure and other issues related to health care consumer protection.

The bill requires the Oregon Health Plan Administrator to establish a consortium of interested parties that shall develop, on a voluntary basis, standardized, quantitative performance measures of managed health insurance organizations for use by health care consumers, purchasers, and providers to assess the quality of clinical and service-related aspects of managed health care. The measure also directs the consortium to produce one or more managed care performance scorecards to provide consumers and purchasers with accurate, reliable, and timely comparisons of managed health insurance organizations.

Effective Date: June 18, 1997

Senate Bill 98

Relating to health insurance portability.

SB 98 modifies provisions relating to health insurance portability, conforming Oregon law with the federal Health Insurance Portability Accountability Act (HIPAA), approved by Congress in 1996. HIPAA established minimum federal standards in several areas of health insurance. Passage of SB 98 ensures enforcement authority for health insurance reform remains with the Department of Consumer and Business Services (DCBS), rather than reverting to the federal government. Regulation of all types of insurance has historically been a matter of state jurisdiction.

The measure makes technical changes to Oregon insurance law, requiring guaranteed acceptance for coverage of all individuals who meet federal eligibility requirements. SB 98 guarantees insurance portability eligibility for Oregon residents, even if their group coverage was provided by a non-Oregon employer. The measure also guarantees availability of coverage to businesses that employ up to 50 employees. Current law limits that guarantee to employers of up to 25 employees.

SB 98 adds technical provisions to current requirements for preexisting conditions and guaranteed renewability in individual, small employer and general group plans. The measure retains separate premium rating requirements for employers with 2 to 25 employees and those with 26 to 50 employees. The measure also makes technical changes to coverage issued by the Oregon Medical Insurance Pool.

Effective Date: August 1, 1997

Senate Bill 235

Relating to Health Professional Regulatory Boards.

SB 235 standardizes health professional regulatory board statutes relating to disclosure of information regarding investigations into licensee and applicant conduct. The measure requires a balancing of public and private interests in the confidentiality of licensure board records and the public interest in disclosure. The potential private interests to be considered may include the privacy and reputations of patients, complainants, informants, and licensees.

Upon receipt of complaint against a licensee or applicant, the measure requires a health professional regulatory board to assign one or more persons to investi-

gate the complaint. The measure requires the investigator to report to board within 120 days of the board's receipt of complaint. The measure requires the report to describe evidence gathered, results of witness interviews and any other information considered in preparing the report of the investigator.

The measure requires information that a board obtains as part of investigation or contested case, consent order or stipulated agreement involving licensee or applicant conduct, including the existence of the complaint and its subject matter, be kept confidential and not disclosed by the board. The measure permits a board to consider, in executive session, information obtained as part of an investigation of licensee or applicant conduct. Public disclosure of minutes, transcripts or recordings related to the substance and disposition of the matter investigated is permitted if the requester demonstrates by clear and convincing evidence that the public interest in disclosure outweighs other interests in nondisclosure, including but not limited to the public interest in nondisclosure.

SB 235 requires a board to disclose a notice of intent to impose a disciplinary sanction, a final order that results from the board's notice of intent to impose sanction, a consent order or stipulated agreement and information to further an investigation of public officials by the Government Standards and Practices Commission. The measure also requires the notice, final order, consent order or stipulated agreement to summarize the factual basis for the board's disposition of the matter investigated.

If a board determines no notice of intent to impose disciplinary sanction shall be issued, SB 235 requires disclosure of information obtained as part of investigation if the requester demonstrates by clear and convincing evidence that the public interest in disclosure outweighs other interests in nondisclosure, including but not limited to the public interest in nondisclosure. A board is required to provide a licensee or applicant seven day's prior written notice describing the record that the board intends to disclose. In any subsequent action for injunctive or declaratory relief, the measure requires those seeking disclosure to demonstrate by clear and convincing evidence that the public interest in disclosure outweighs other interests in nondisclosure, including but not limited to the public interest in nondisclosure.

The measure provides immunity from civil liability for individual who, in good faith, supplies information to

a board or a committee reporting to a board.

The measure clarifies that all communications with peer review investigators shall be held confidential. This provision was included in response to a recent court decision ordering disclosure of oral communications with peer review investigators. The measure also protects oral and written communications which trigger peer review, such as a report of a patient care incident to a supervisor and the supervisor's investigation of the report prior to formally referring the matter to the peer review body. Proponents assert that these protections are necessary to ensure the free flow of information necessary for effective peer review.

Finally, the measure establishes a procedure for Attorney General review of health professional regulatory board denials of requests to inspect board records. The measure requires a petitioner to send a copy of the petition for review to the board and requires the board to forward copy of petition to licensee or applicant who is the subject of any record for which disclosure is sought, together with notice that the licensee or applicant may file with the Attorney General a response to the petition. The measure requires the individual seeking disclosure to establish by clear and convincing evidence that the public interest in disclosure outweighs other interests in nondisclosure, including but not limited to the public interest in nondisclosure. The Attorney General must grant or deny the petition within 15 days of receipt, and send a copy of the order to the board, the petitioner the licensee or applicant. The measure prohibits a board from disclosing any record prior to seven days following the service of the Attorney General's order on licensee or applicant.

SB 235 grants standing to a board, licensee or applicant, or person denied right to inspect or receive copy of any public record of a health professional regulatory board to institute proceedings for injunctive or declaratory relief in the circuit court for the county where the public record is held and establishes the burden for such proceedings.

Effective Date: October 4, 1997

Senate Bill 312

Relating to insurance coverage for medically reasonable drug use.

SB 312 requires insurance policies and contracts providing coverage for drugs approved by the Food and Drug Administration (FDA) to also provide coverage,

under certain conditions, for drug use not officially approved by the FDA. The measure requires coverage if the use is generally recognized as appropriate by the medical community as evidenced by the use being stated in publications equivalent to the United States Pharmacopoeia drug information, the American Medical Association drug evaluations, the American Hospital Formulary Service drug information, or in scientific studies published in peer-review medical literature.

The FDA permits drugs to be marketed only for their approved purpose. Once a drug is approved for one purpose, however, physicians may legally prescribe it for other "off-label" purposes. Off-label use is most common in treatment of cancer, but insurers may or may not cover the cost.

Effective Date: October 4, 1997

Senate Bill 412

Relating to anesthesiology.

SB 312 requires the State Board of Nursing to adopt a scope of practice for certified registered nurse anesthetists (CRNAs). The measure requires the board to establish procedures for issuing a certification of special competency for CRNAs. The measure specifies that anesthesia care in an ambulatory surgical center shall be delivered by an anesthesiologist or by a CRNA acting with the medical collaboration of an anesthesiologist, allowing a CRNA to deliver specified services without medical collaboration if no anesthesiologist is readily available. The measure allows ambulatory surgical center by-laws, rules, and regulations to establish requirements, consistent with the scope of practice, for ready availability of an anesthesiologist for medical collaboration with a CRNA.

The measure allows a CRNA to deliver specified services without medical collaboration in a hospital and permits hospital rules and regulations to define whether a CRNA may deliver services independently or be required to be supervised by or collaborate with an anesthesiologist. The measure specifies that other health care professionals are not prohibited from rendering anesthesia services if doing so is within their scope of practice (i.e., dentists and oral surgeons).

Current law is silent as to whether a CRNA may act independently or under the supervision of an anesthesiologist or other medical doctor. This measure was introduced in response to concern as to whether CRNAs practicing independently have the authority to do so.

The measure legitimizes the current practice in Oregon. While some hospitals utilize CRNAs as independent practitioners, some require CRNAs to act under the supervision of an anesthesiologist or other medical doctor. This measure does not require a change in either practice.

Effective Date: October 4, 1997

Senate Bill 435

Relating to emergency medical technicians.

SB 435 allows emergency medical technicians (EMTs) to provide non-emergency care within their scope of practice, as determined by the Board of Medical Examiners. Current law authorizes EMTs to provide emergency care only. However, EMTs often provide non-emergency care in the course of their work, particularly while transporting patients between facilities.

Effective Date: October 4, 1997

Senate Bill 467

Relating to health.

SB 467 makes a number of changes to the Medical Practice Act. The measure bifurcates the process by which the Board of Medical Examiners reviews and takes disciplinary action against licensees, prohibiting board members (except one public member) who participate in an investigation from participating in the board's final action on the same matter. The measure specifies that a meeting of the board to determine what further action should be taken is not part of the investigation.

In the case of an investigation, the measure requires the board to provide a licensee with a current summary of the complaint being investigated at least five days prior to the date that the licensee is to appear or respond. The measure permits the withholding of complainant's name and prohibits the licensee or the licensee's representative from knowingly contacting the complainant until the licensee requests a contested case hearing.

The measure requires particular mental states for certain disciplinary actions to occur. For disciplinary action to occur for insanity or a mental disease for which a licensee is voluntarily committed, the measure requires that the illness affect the licensee's ability to safely practice medicine. If the board has evidence indicating a licensee's incapacity, the measure permits the board to order a licensee to submit to a standard-

ized competency examination. The measure also permits the board to discipline licensees who do not provide statutorily required notice of risks to patients prior to prescribing controlled substances for treatment of intractable pain.

SB 467 specifies that diversion program records are not admissible as evidence in any judicial, administrative, arbitration or mediation proceeding except proceedings between the licensee or applicant and the Board of Medical Examiners. The measure prohibits disciplinary action against a licensee who voluntarily participates in, and successfully completes, a diversion program unless the licensee is suspected of habitual or excessive use of intoxicants, drugs or controlled substances, or a violation of the Federal Controlled Substance Act. In deciding whether to discipline a licensee for a standard of care violation, the measure requires the board to determine whether a licensee acted as an ordinary careful physician in the same or similar circumstances in the licensee's community or similar community.

Of the seven physicians on the board, the measure requires appointment of at least one from each congressional district and changes the term of board members from four to three years. The measure prohibits members from serving more than two consecutive terms.

SB 467 clarifies that all communications with peer review investigators shall be held confidential. This provision was included in response to a recent court decision ordering disclosure of oral communications with peer review investigators. The measure also protects oral and written communications that trigger peer review, such as a report of a patient care incident to a supervisor and the supervisor's investigation of the report prior to formally referring the matter to the peer review body. SB 467 also transfers oversight of respiratory therapist licensing from the Board of Medical Examiners to the Health Division.

Effective Date: August 5, 1997

Senate Bill 507

Relating to reimbursement of rural hospitals for health services.

SB 507 requires health care providers participating in the Oregon Health Plan (OHP) to reimburse Type A and B rural hospitals for the full cost of services provided to OHP members.

The Office of Medical Assistance Programs (OMAP), Oregon's Medicaid authority, is required by law to cause Type A and Type B rural hospitals to be reimbursed fully for the cost of covered services. Proponents assert that OMAP is subverting the statutory requirement to cause providers to be reimbursed for the full cost of services simply by using an intermediary (OHP contractors) to pay hospitals and physicians.

Effective Date: October 4, 1997

Senate Bill 825

Relating to public assistance.

In August 1996 Congress passed the Personal Responsibility Act of 1996, which replaced the Aid to Dependent Children program with a new program called Temporary Assistance to Needy Families (TANF). SB 825 conforms Oregon law with the federal legislation and deletes outdated statutory provisions. The measure authorizes the Adult and Family Services Division (AFS) to enter into contracts and intergovernmental agreements to provide job services, reduce unintended pregnancies, and make referrals for community, medical, and social resources. It also authorizes AFS to establish and implement local district pilot projects to promote work skills, education, and employability, and to offer client incentives to move toward self-sufficiency. The unemployed parents program will be continued through the summer months under SB 825. The measure establishes sanctions for individuals who refuse to participate in a mental health or drug abuse evaluation, and prohibits the denial of public assistance based on a drug-related felony conviction.

Effective Date: July 23, 1997

Senate Bill 867

Relating to health benefits provided by public entities.

SB 867 allows school districts to operate self-insured health benefit programs for district employees and students. SB 867 also specifies the minimum required elements for self-insured employee health insurance programs offered by public entities, and requires any such program provided by a school district to meet the same requirements.

Several Oregon public entities are at least partially self-insured for their employee health insurance programs. These include the cities of Eugene, Salem, and Port-

land, as well as the Port of Portland. Entities that self-insure are subject to mandated benefits established by the legislature and reporting requirements of the Insurance Division of the Department of Consumer and Business Services (DCBS).

Effective Date: October 4, 1997

Senate Bill 911

Relating to health insurer coverage of emergency treatment.

SB 911 requires insurers offering a health benefit plan to provide coverage, without prior authorization, for emergency medical screening exams and stabilization of an emergency medical condition. The measure requires coverage of services provided by a nonparticipating provider if a prudent layperson possessing an average knowledge of health and medicine would reasonably believe that the time required to go to a participating provider would put his or her health in serious jeopardy.

The measure also requires insurers to provide information to enrollees regarding what constitutes an emergency medical condition, coverage for emergency services, how and where to obtain emergency services, and the appropriate use of 9-1-1. The measure prohibits an insurer offering a health benefit plan from discouraging the appropriate use of 9-1-1 and from denying coverage for emergency services solely because 9-1-1 was used.

Effective Date: October 4, 1997

Senate Bill 934

Relating to domestic violence.

SB 934 prohibits health insurance discrimination against victim of domestic violence. The measure also prohibits insurers from considering, as underwriting criteria, the fact that an insured or prospective insured has been the victim of domestic violence. The measure specifies that an insurer is not prohibited from taking actions otherwise permissible by law, and in the same manner with respect to all insureds, without regard to whether insured or prospective insured is a victim of domestic violence.

Since medical care is often the first line of support for victims of abuse, health care professionals are often the first to inquire about abuse and provide information and access to safety. Proponents assert insurance

discrimination deters victims from care, information, and avenues of escape.

Effective Date: October 4, 1997

Senate Bill 979

Relating to insurance benefits for public employees.

SB 979 requires the State Employees Benefit Board (SEBB) and Bargaining Unit Benefits Board (BUBB) to make long term care insurance available for purchase by public employees. The measure specifies that plans shall be available to family members of eligible employees.

The measure requires SEBB and BUBB to provide information on the potential need for long term care and financing methods and to develop, in consultation with the Public Employees' Retirement System, long term care plan design, eligibility rules, underwriting principles, and educational materials in order to allow eligible employees to continue to participate in the plans after retirement and to allow former employees to enroll in the plans after retirement.

For persons age 65 and older, Medicare offers only a limited long term care benefit for 100 days of skilled nursing care following an acute care episode. Once that benefit is exhausted, individuals not eligible for Medicaid, or that do not have long term care insurance, must pay out-of-pocket for any necessary care.

Effective Date: October 4, 1997

Senate Bill 1071

Relating to the Pain and Symptom Management Task Force.

SB 1071 establishes the Pain and Symptom Management Task Force consisting of representatives of consumer groups, nurses, home health care workers, social workers, pharmacists, public health workers, actuaries, insurance providers, and other professionals working in education, law, and medicine. The measure requires the task force to undertake a specific study, including the problems in obtaining relief from pain faced by Oregonians with chronic or terminal illness, the nature of current pain and symptom management practices, and the resources and remedies available for pain and symptom management. The measure requires the task force to report recommendations for policy changes to the 70th Legislative Assembly.

Proponents of the measure agree that there is much to

be learned about providing optimal care for patients with terminal or chronic illness. Providers must balance patient requests for medications or treatments to relieve symptoms with provider responsibility to ensure that drugs are not being abused. The Health Division supports the identification of best practices and recommendations for necessary policy changes as advantageous for patients and the entire health care community.

Effective Date: October 4, 1997

Senate Bill 1107

Relating to genetics.

SB 1107 permits the anonymous testing of genetic material; including tissue and blood, but maintains an individual's property right to their own genetic information. The measure exempts from mandatory destruction DNA samples used for anonymous research. SB 1107 eliminates the right of an individual or individual's representative to inspect, request correction of or obtain genetic information from an individual's records if the genetic information has been made anonymous by destruction of all information that could allow disclosure of the identity of the individual who provided the sample. Where there is no pecuniary interest, the measure specifies that a person does not interfere with an individual's property by obtaining or providing an individual's genetic information or DNA samples for anonymous research.

Effective Date: October 4, 1997

House Bill 2013

Relating to respite care.

HB 2013 establishes the Community Lifespan Respite Care Program within the Department of Human Resources. HB 2013 begins a six-year phase-in to establish respite care infrastructure in each county or region in Oregon. At the state level, HB 2013 establishes statewide technical assistance, policy analysis, and coordination to promote efficiency and reduce duplication.

Respite care is temporary, short-term care of children and adults with disabilities, medical conditions, special needs or those at risk of abuse and neglect. The primary purpose of respite is to provide relief from the extraordinary and intensive demands put on ongoing care providers.

An Oregon Lifespan Respite Care Program will provide a point of contact in each county or region for

families to access respite care. This point of contact will provide families with assistance in locating community resources, financial assistance, training information, and support. Prior to enactment of this measure, some level of respite care was available in all but nine Oregon counties, but no state wide coordination to provide information or direction to individuals in need of respite care was available.

Effective Date: August 4, 1997

House Bill 2044

Relating to civil liability.

HB 2044 states that a person who acts as a good Samaritan in rendering medical assistance or transporting an injured person is not liable for damages unless that person was grossly negligent in rendering the emergency medical assistance or transportation.

Current law specifies doctors, dentists, nurses, osteopaths, naturopathic physicians, chiropractors and, to a limited extent those certified in cardiopulmonary resuscitation, are immune from liability so long as they operate within the standards of reasonable care in administering emergency medical assistance.

Effective Date: October 4, 1997

House Bill 2174

Relating to vital statistics.

HB 2174 conforms Oregon vital records law to federal standards in order to create a policy foundation for confidentiality, paternity establishments, access to records, and penalties for failure to comply with vital record statutes. The measure designates those able to obtain vital records and vital reports and the information to be included in vital records. In addition, HB 2174 creates the offense of unlawful use of vital records or vital reports, and the offense obstructing the keeping of vital records or reports.

Effective Date: October 4, 1997

House Bill 2328

Relating to hospitals.

HB 2328 requires notice to the Attorney General prior to sale of a publicly owned hospital to a for-profit corporation. The measure permits the Attorney General to require public hearings and disclosure of the terms and conditions of the sale.

Effective Date: October 4, 1997

House Bill 2388

Relating to mandatory health insurance coverage for certain medical conditions.

HB 2388 requires health benefit plans to reimburse providers for the treatment of specified metabolic disorders and the special medical foods required by persons with the disorders. Medically, these disorders are referred to as inborn errors of metabolism. The most common and recognizable is phenylketonuria, (PKU). Newborn children with these disorders may suffer a variety of ailments, including profound retardation. Severe cases result in death.

Oregon was the first state to require testing of all newborns for PKU. Special medical foods that have been chemically altered may prevent the condition from causing disability.

Effective Date: July 3, 1997

House Bill 2488

Relating to taxation.

HB 2488 permits Oregonians to establish tax-deductible medical savings accounts (MSAs), notwithstanding federal limits on the maximum number of eligible account holders.

As part of a federal pilot program, the 104th Congress adopted legislation allowing federal tax deductions on funds deposited into MSAs. Under the federal program, the total number of MSAs nationwide will be capped in 1999 at 750,000 and limited to employees of small employers (50 or fewer employees). The 750,000 MSAs must meet certain requirements and eligibility standards. HB 2488 makes available a state tax deduction to all MSA participants who meet the requirements of the pilot program, regardless of whether or not they are a part of the 750,000 who will be eligible to receive a federal tax deduction. While HB 2488 relaxes the cap on the number of MSAs in Oregon, it does not alter the federal eligibility conditions.

The measure applies to tax years beginning on or after January 1, 1998.

Effective Date: October 4, 1997

House Bill 2827

Relating to limited access permit dental hygienists.

HB 2827 permits dental hygienists, without the supervision of a dentist, to provide preventative and thera-

peutic dental services to persons with limited access to that care, including those who live in nursing homes and other institutional settings.

Effective Date: October 4, 1997

House Bill 2894

Relating to the Oregon Health Plan.

HB 2894 establishes the Family Health Insurance Assistance Program (FHIAP) within the Insurance Pool Governing Board (IPGB). Assistance vouchers are to be issued through FHIAP to eligible applicants for purchase of health insurance based on a sliding scale determined by family size, family income, the number of family members to receive FHIAP subsidies, and any other factors that IPGB establishes by rule. HB 2894 requires eligible individuals to enroll in group health insurance to which their employer contributes. Based on recommendations made by the Office of Oregon Health Plan Policy and Research, IPGB may establish minimum benefit requirements for individual health insurance policies subject to subsidies by FHIAP. The measure specifies that vouchers may not be issued to adults in a family unless all the children are covered by health insurance or Medicaid. HB 2894 allows the IPGB to prohibit or limit enrollment in FHIAP to meet funding limits by lowering the allowable income level to qualify or by establishing a waiting list. This will allow the IPGB to provide the FHIAP to Oregon families up to 150 percent of the federal poverty level (monthly household income up to \$2,006 for a family of four). Current funding for FHIAP is \$24 million for the 97-99 biennium. It is estimated that this funding will enable FHIAP to assist 20,000 people in obtaining health insurance.

Ballot Measure 44 (1996) increased Oregon tobacco taxes, specifying a percentage of the additional revenue raised be used for both maintenance and expansion of the Oregon Health Plan. In October 1996, the Oregon Health Council submitted its "Recommendation on Expansion of Access" to the Governor and the Legislative Assembly. This recommendation advocated for creation of a program to assist uninsured Oregonians with incomes above the federal poverty level who cannot afford health insurance. As a result of the passage of Ballot Measure 44, the Governor directed the Oregon Health Council to determine the next phase of assistance to Oregonians who currently lack health insurance. The Family Health Insurance Assistance Program embodied in HB 2894 reflects the policy recommendations made by the Oregon Health Council to pro-

vide medical services subsidies for that population.

HB 2894 also directs the Office for Oregon Health Plan Policy and Research to conduct two interim studies. The first, addressing policy issues related to prepaid managed care health services contracts, arose from concern regarding the adequacy of the geographical differential utilized by the Office of Medical Assistance Programs to determine reimbursement rates across the state. The second directs a review of the Medicaid demonstration program administered by the Office of Medical Assistance Programs. The measure requires a comparison of effectiveness and efficiency of the current Medicaid demonstration program and the Medicaid program operated prior to the establishment of the Oregon Health Plan. The measure also requires the same comparisons with other state Medicaid programs utilizing managed care under Section 1115 waivers from the federal government.

Finally, HB 2894 changes the title of the Oregon Health Plan Administrator to the Administrator of the Office for Oregon Health Plan Policy and Research and changes the name of the Office to the Oregon Health Plan Administrator to the Office for Oregon Health Policy and Research.

Effective Date: July 28, 1997

House Bill 2954

Relating to Oregon Death with Dignity Act.

HB 2954, upon voter approval in November 1997, repeals the Oregon Death with Dignity Act. In November 1994, voters approved Ballot Measure 16, permitting physicians, under limited circumstances, to prescribe life-ending medication for terminally-ill, but mentally capable patients. A United States District Court found the act unconstitutional and issued a stay against its operation. The Ninth Circuit overturned that decision, but the stay is in effect pending appeal to the United States Supreme Court.

Effective Date: June 19, 1997

House Bill 3112

Relating to domestic violence.

HB 3112 requires the Adult and Family Services Division (AFS) to identify Temporary Assistance to Needy Families applicants who are victims of, or are at risk of victimization by, domestic violence. The measure directs AFS to waive specified requirements for those persons. In addition, AFS is required to refer those

identified to counseling and support services. Proponents of the measure assert that in order to eliminate economic barriers that may preclude a victim of domestic violence from leaving their abuser, public assistance should be made more readily accessible.

Effective Date: October 4, 1997

House Bill 3657

Relating to licensed mental health technicians.

HB 3657 establishes the mental health technician registration pilot program to be implemented by the Mental Health and Developmental Disabilities Services Division (MHDDSD) in a single geographic area of the state designated by the division. MHDDSD is directed to establish a registration system for mental health technicians in consultation with the counties and community colleges in the geographic area in which the pilot program is implemented. The measure prohibits individuals from acting as a mental health technician within the geographic area unless they are registered with MHDDSD. MHDDSD and the 70th Legislative Assembly are required to review the pilot program. If it is determined that the pilot program has been successful, the program shall be implemented statewide no later than July 1, 1999.

Effective Date: October 4, 1997

Measures Vetoed by the Governor

Senate Bill 397

Relating to F.H. Dammasch State Hospital.

SB 397 requires the sale of the F.H. Dammasch State Hospital property and utilization of 100 percent of the proceeds to provide access to and maintenance of community-based housing for the chronically mentally ill. The measure specifies that the property may only be used for the purposes of a mixed-use urban village.

Governor's Veto Message (June 26, 1997):

I am returning herewith Senate Bill 397, unsigned and disapproved. Senate Bill 397 requires that the F. H. Dammasch State Hospital property shall be sold without regard to the recent siting of a corrections intake center and women's correctional facility on this state-owned property.

While I respect the legislative statement made by passage of the Senate Bill 397, I am disappointed that the legislature failed to provide an alternative solution for the siting of the correctional facilities which are intended to be constructed on this property.

This veto should not be a surprise to anyone. I have been very clear about my position on this issue.

If the legislature desires to prevent the construction of any correctional facility which has been sited in the last seven months, it is incumbent on the legislature to also identify and site a cost-effective alternative.

I accepted the responsibility to site prisons conferred on me by the 1995 Legislative Assembly and I have carried out that duty in a responsible and forthright manner. The decision to site on the hospital property was not an easy one, but it was a responsible one given the careful and diligent process to identify acceptable prison sites in the tri-county metropolitan area.

Senate Bill 966

Relating to Oregon Health Plan.

SB 966 prohibits the Department of Human Resources from considering state geographic zones in setting Oregon Health Plan capitation and reimbursement rates.

Current law requires that Oregon Health Plan (OHP) rates reflect the reasonable cost of providing care. Once the legislature approves the OHP budget, an actuarial analysis determines per capita costs for each service on the prioritized list, establishing a statewide rate. Geographic factors are then applied to the statewide rate to determine the actual capitation rate for each geographic area. According to the Office of Medical Assistance Programs (OMAP), geographic adjustment factors are calculated based upon the differences in costs for specific types of services as determined by the federal Health Care Financing Administration (HCFA). Currently, there are five geographic zones: Multnomah, Clackamas, and Washington Counties; Linn, Benton, Marion, Polk, and Yamhill Counties; Lane County; Jackson, Josephine, and Douglas Counties; and the remainder of the counties in the state.

To effect the rate change, OMAP must file an amendment to the OHP Medicaid Demonstration waiver. HCFA will require the state to prove that the rate change would not have a negative impact on client access to care in the Portland metropolitan area and Lane County. That is, that a rate decrease in urban areas would not result in providers refusing OHP clients.

Proponents of the measure disagree with the current rate-setting structure, asserting that the cost of doing business in rural communities is no less expensive than in urban communities. In fact, proponents assert that some costs are actually higher: transportation services (ambulance and air flight) are costlier due to long distances and some rural areas have found that attracting physicians can be difficult and expensive.

Governor's Veto Message (August 8, 1997):

I am returning herewith SB 966, unsigned and disapproved.

SB 966 prohibits the consideration of geographical cost differences or prices in the development of capitation rates for managed care plans participating in the Oregon Health Plan Medicaid Demonstration. Currently, rates are adjusted according to geographical differences in input costs, based on the Health Care Financing Administration. At present, this is the best data we have available for this purpose.

While there are numerous claims that the aggregate per capita cost of providing health care is equal around the state, I have yet to see systemically based data that supports this claim. Conversely, there is a substantial body of Oregon specific data including, but not limited to, the cost of capital assets, labor costs, and the patterns of utilization, that supports the position that there are differences in the aggregate of providing care in various areas of the state. While I am open to new information that demonstrates otherwise, I am unwilling to change our current practice and run the risk of compromising access to care for Medicaid patients in certain areas of the state without first having something more than anecdotes on which to base such an action.

As was noted during administration testimony, SB 966 would decrease payments to plans in areas of the state with higher costs and increase rates in other areas where data show costs are lower. This creates the potential for a decrease in access in areas where most of the Oregon Health Plan members reside.

Another bill passed during the session, HB 2894 B Engrossed, addresses the issue of rate equity in a more considered way. It establishes a broad based advisory committee to the Office for Oregon Health Plan Policy and Research. The committee is charged with researching the issue of geographic rate adjustment and with recommending to OMAP specific capitation rate ad-

justment factors. In turn, OMAP is then directed to develop the 1999-2001 budget based upon these recommendations.

The advisory process identified in HB 2894 is an open one and allows for stakeholder participation.

It also provides time for the health plans to prepare for any potential changes that would be required of OMAP.

I believe that a process which considers the expertise of actuaries, the affected parties from both high and low cost areas, and client access to care will result in the best outcome

House Bill 2157

Relating to hospital reimbursement.

HB 2157 permits the Department of Corrections (DOC) to establish the rates at which it reimburses hospitals for the cost of inmate care. The measure requires the DOC director to utilize the cost-to-charge ratio fee schedule established by the Department of Consumer and Business Services for payment to hospitals for inpatient and outpatient services, unless the DOC has negotiated an alternative reimbursement agreement.

The Department of Corrections rule-making process in late 1996 raised the question of whether the department needed specific authority to set a fee schedule for hospital reimbursement rates. In response to that concern, the department requested introduction of this measure which provides the department with specific authority to set hospital reimbursement rates.

Governor's Veto Message (August 15, 1997):

I am returning herewith HB 2157 unsigned and disapproved.

House Bill 2157 requires the Department of Corrections to pay more for hospital care provided to inmates than is currently paid by the agency. While the legislation did allow the agency to negotiate alternatives to the rate set in the bill, the guaranteed rate substantially reduced the possibility that an alternative could be negotiated.

I am determined to operate our state prisons cost effectively and medical care that must be provided to prisoners is one important component of the daily costs of housing prisoners. However, I have a long commitment to a health care agenda that reimburses hospitals and providers adequately and appropriately for their ser-

vices. Although I am vetoing this bill, I want to communicate to everyone concerned that I expect the Department of Corrections to pay adequate and appropriate rates for health care provided to prisoners by hospitals.

To this end, I have directed the Office for the Oregon Health Plan Policy and Research to assist the Department of Corrections in the review and establishment of a method to reimburse hospitals for services provided to inmates. Reimbursement of hospitals for services provided to inmates should take into account the level of health care this particular population requires, the system for delivery of health care in the prisons, the share of the prison population hospitals are expected to service, as well as the economic factors that influence health care costs in different geographic regions of Oregon. These are complex questions which must be answered in order to establish reasonable rates for reimbursement of health care services. This should be negotiated community by community.

I am directing the Department of Corrections to rescind the current rules establishing a hospital reimbursement rate. The veto of House Bill 2157 provides time for the Department of Corrections to establish reasonable rates for the reimbursement of hospitals for services provided to state prisoners.

With the assistance of the Administrator for the Office of the Oregon Health Plan Policy and Research hospital organizations will have the opportunity to participate in the analysis and consideration of rates for reimbursement for services delivered.

House Bill 3310

Relating to long term care.

HB 3310 creates the Joint Legislative Task Force on Long Term Care and Senior Health Issues. The task force is required to undertake specific studies and make legislative recommendations regarding long term care issues, presenting the results of the study and its recommendations to the 70th Legislative Assembly.

In addition, HB 3310 deletes the requirement that the Oregon Veteran's Home obtain a certificate of need for a new long term care facility and exempts the Oregon Veterans' Home from the statutory requirement to obtain a certificate of need (ORS 442.315). In 1993, the legislature approved the first Oregon Veterans' Home, which is currently under construction in The Dalles and is expected to open in 1997. In 1995, Oregon applied

for a second veterans' home location. As a condition of application, the legislature required the Department of Veterans' Affairs to complete a certificate of need application. Certificates of need are required to evaluate demand for health care facilities and equipment. Certificates are issued by the Oregon Health Division of the Department of Human Resources.

Governor's Veto Message (August 8, 1997):

I am returning herewith HB 3310, unsigned and disapproved.

Oregon has pioneered the way for reforming the nation's long term care systems. We have listened carefully to both taxpayers and older Oregonians. As a result we have developed a long term care system which costs less per person served and saves millions of dollars per year when compared to many other states. In addition, we serve the frail elderly first in their own homes, in community based assisted living facilities, in foster care and only as a last resort, in high cost and restrictive nursing homes. This is the care system our seniors say is best, and this is the efficiency taxpayers say they want.

House Bill 3310 runs contrary to these important policy objectives. It builds a new facility with public dollars when all available data indicates more nursing homes are not needed in our state. It may require veterans who use it to move a substantial distance from their homes and loved ones in order to take advantage of the care it offers. It is a product of an out of date federal system which ignores the national preference of most veterans to stay in their home community. This federal policy creates a perverse incentive by providing over \$2,000 per month in subsidies if they move to a Veteran's nursing home, but only provides \$90 per month for personal needs if they choose a nursing home in their own community. This policy does not honor our veterans as they deserve nor does it allow the services needed by our veterans to be purchased economically and efficiently. Attached to this veto message is a letter I have written to our congressional delegation asking them to begin working immediately to change this outdated approach to long term care.

Not only is this approach unfair to many veterans who wish to receive assistance from the Veterans Administration and who do not want to leave their home town, it is unfair to other older Oregonians.

While veterans organizations support the Coquille project many of the organizations who represent the general population of older Oregonians do not. Groups opposing HB 3310 include the Governor's Commission on Senior Services, the Oregon State Council of Senior Citizens, the United Seniors of Oregon and the Oregon Disabilities Commission. These organizations understand that the stability of the long term care system that serves other frail Oregonians and our ability to control costs in that system depend on how effectively we are able to control the supply of nursing home beds in each region of our state. For these reasons, they believe that the Coquille project should meet the same need criteria that all other new nursing facilities are required to meet before construction. I agree with these groups that this is the best way to balance the needs of both veterans and the general population of Oregon's frail elderly.

There is also a concern about the fairness and validity of the economic development aspects of the Coquille project. Currently, there is no documented evidence that veterans who need nursing home care cannot obtain that care. The Oregon Department of Veterans Affairs (ODVA) cites anecdotal instances but neither the ODVA nor the Oregon Senior and Disabled Services Division (SDSD) can document a sufficient need to warrant opening a new facility. If there is not a significant unmet need for nursing facility beds for veterans, the only way that the Coquille facility can be filled is to draw patients from other facilities around the region within which the home is built. Thus, there is the clear possibility that any economic gain experienced in Coquille will come at the expense of jobs being lost in other towns in the region. If this were not to occur because veterans prefer to stay in their own home towns as discussed earlier, then the Coquille facility would likely not be able to meet the 95% occupancy required for its success. This leaves the state with the choice of either shifting jobs from other Oregon communities to Coquille, or being forced to continue to operate a facility in Coquille which is significantly underutilized and which falls far short of the economic expectations of those who have worked so hard to site the home there.

Adding to this uncertainty is the scheduled opening of a large new veterans nursing home in The Dalles in October of this year. Starting this project has necessitated a loan from the War Veterans' Trust Fund of \$1.3 million which will take over three years to begin paying back and will not be fully amortized for ten years. This coupled with the lack of any experience in operat-

ing such a facility would suggest the prudent course to take would be to see how the project in The Dalles works out before committing to another project the size of the one in Coquille.

Finally, let me make clear that I support the study of our long term care system that is the largest part of HB 3310. While the statutory directive for this study will be lost with my veto of this legislation I will work to fulfill this desirable portion of the bill through other means.

The decision to veto HB 3310 has been a difficult one. I know that the economic situation on the south coast is serious, and that many well meaning, honorable, and dedicated Oregonians are actively supporting this project. I also know this action will be unpopular with some powerful interest groups. I pledge to continue to work with veterans groups and the city of Coquille to improve both the plight of Oregon's veterans and the economy of the community. However, I believe that ultimately, the best interests of veterans, other older Oregonians, Coquille, the south coast in general, and the state as a whole will be better served by my veto of this legislation.

House Bill 3502

Relating to a special election.

HB 3502 specifies the title for the ballot measure repealing the physician-assisted suicide law: "Repeals Law Allowing Prescription Of Lethal Drugs To Terminally Ill." The measure also specifies the summary and the results of a "yes" or "no" vote, both of which will appear on the November 1997 ballot.

Governor's Veto Message (July 29, 1997):

I am returning herewith HB 3502 unsigned and disapproved.

House Bill 3502 prescribes in law the ballot title for the referral of HB 2954, the repeal of 1994 Measure 16, passed by the voters, which allowed physician prescription of lethal drugs for terminally ill adults. It also specifies the brief summary and a statement of the result of a "yes" and a "no" vote that would appear on the ballot.

Ballot measure titles are perhaps the single most critical factor in informing voters about the substance of measures on which they will be voting. Because of this, it is extremely important the titles be drafted carefully to fairly reflect the substance and consequences of the measure.

I am vetoing HB 3502 because it is unfair and unnecessary. It is unfair because advocates from both sides of this very volatile issue were not included in the drafting process. It is unnecessary because Oregon statutes establish a well-defined and objective process for drafting ballot titles for initiatives and referrals.

The authors of HB 3502 — passionate advocates on one side of the measure — seek to by-pass part of the established procedure. They have fashioned an incomplete title for the measure, omitting many of the important features of Measure 16 which were included in the 1994 ballot title written by the Attorney General, approved by the Supreme Court, and sent to the voters. Indeed, the measure even omits any mention that this referral is a re-vote on the exact measure the voters passed in 1994.

Under Oregon's long-established ballot title drafting process the Attorney General is charged with writing a clear and fair ballot title. This title is then subject to comment by both proponents and opponents of the measure. The Attorney General must respond to these comments and certify the title. Interested parties have the ability to appeal the certified title to the Supreme Court. The Court then considers the title and may modify it as the court sees fit. In the case of the present measure, there is no good reason to ignore this deliberative and objective process.

I am also very concerned about the process by which HB 3502 was passed by the legislature.

Doctor-assisted suicide was one of the most controversial and complex measures considered by the legislature this session. While the legislature did indeed dedicate a significant amount of time to investigating how Measure 16 could be strengthened, it spent almost no time considering the appropriateness of the ballot title language in HB 3502. The House held no public hearings on the bill and the Senate held a brief hearing in the rush of the final day of the session. A measure of this importance deserves much better.

In vetoing HB 3502 I am confident that the Attorney General and Supreme Court will present Oregon voters with a fair and complete ballot title for Measure 51

on the November ballot. The voters will then be able to once again pass considered judgment on the merits of a doctor-assisted suicide measure.

Major Legislation

Not Enacted

Senate Bill 31

Relating to health insurance.

SB 31 would have required health insurance policies to allow insureds to use any drug outlet or pharmacist offering to provide services on insurer's terms for costs and reimbursements. The measure would have required policies to allow any drug outlet or pharmacist agreeing to the insurer's terms to provide services.

Senate Bill 406

Relating to Fairview Training Center.

SB 406 would have required the Mental Health and Developmental Disability Services Division (MHDDSD) of the Department of Human Resources to develop a plan for the relocation of Fairview residents and present the plan to the legislature on or before January 31, 1998. The plan required by SB 406 was similar to that which MHDDSD had already embarked upon, requiring an individualized plan for each Fairview resident, a detailed accounting of costs to be incurred during the closure and transition, a detailed analysis of cost of implementation of closure over the next four biennia, the selecting of qualified providers of community-based services, the development of appropriate housing alternatives, improving work force stability, and reducing staff turnover at community-based service programs by phasing in improvements in compensation. The measure would have also required the sale of the Fairview property and the proceeds expended solely for capital expenses for community-based services to developmentally disabled individuals and their families.

Senate Bill 1017

Relating to cloning.

SB 1017 would have made it unlawful for any person to engage in human cloning. The measure defines human cloning as the duplication of an existing or previously existing human being by transferring the nucleus of an adult, differentiated cell into an oocyte in which the nucleus has been removed and implanting the re-

sulting product for gestation and subsequent birth.

House Bill 3689

Relating to public assistance recipients.

HB 3689 would have exempted a recipient of public or general assistance or social services from mandatory employment or other work activity programs if the recipient is the grandparent or grandparent's spouse providing daily supervision of a dependent grandchild. In addition, HB 3689 would have permitted persons disqualified from federal benefits due to their status as legal non-citizen residents, or due to a period of incarceration that has been served, to apply for state-funded benefits.

House Bill 3697

Relating to health professions.

HB 3697 would have created the Health Care Licensing Oversight Authority to regulate and monitor health professional licensing boards. The measure proposed consistent membership of seven members per board, including three public members appointed by the Governor and approved by the Senate, all to serve three-year terms.

