

End-of-Session Report

Prepared for ORHA

2009 Session Scorecard

Result	Issue	Bill #	Details
⇔ or ↑	Rural health tax credit sunset	HB 2067	Turned negative (new sunset) into positive (extended through 2024 for those who qualify in 2013). Tax credit to be reviewed before 2014. Ultimate outcome could be neutral or positive depending on the results of the review in 2012 or before.
⇔	Move loan repayment to Office of Rural Health	HB 2581	Passed bill on House floor and in Senate committee. Chose not to pursue because program and administrative funding was zeroed out (see below).
↓	Loan repayment funding for rural healthcare providers	HB 2632 & HB 5544	The proposal to increase the loan repayment budget to \$3 million (HB 2632) did not gain traction. The \$474,000 biennial appropriation was zeroed out in HB 5544 as part of \$2 billion budget cuts. HB 5544 is the Oregon Student Assistance Commission's budget.
↑	Universal health care	HB 2009 & HB 2116	Creates new Oregon Health Authority. Expands OHP coverage to 80,000 children and 50,000 low-income adults.
⇔	Primary care workforce	DHS budget note and HB 3418	Despite discussion about the importance of primary care, few concrete steps were taken to bolster the primary care workforce. Elimination of the rural health loan repayment program was a setback. A process was put in place to increase reimbursement for primary care homes.
↑	Limited licenses for rural MD's	HB 2435	Changed to license by endorsement allowing Oregon Medical Board to accept documents from other states to speed up MD licensing process.
↑	OHP rural health prompt pay	SB 37	Speeds up OHP payments to rural clinics from 9 months to 45 days.
↑	Telemedicine	SB 24	Creates standards for what telehealth services will be paid by commercial insurers.

SESSION SUMMARY – ORHA’S OBJECTIVES

Though we made strides on a number of our priorities, and averted a potential disaster with the rural health tax credit sunset, it felt like rural health lost ground when funding was eliminated for the rural health loan repayment program.

1. **Rural health loan repayment.** Not only were efforts to move the Rural Health Loan Repayment program to the Office of Rural Health unsuccessful, legislators also eliminated funding for the loan repayment program. This was a major setback though it has motivated some legislators to begin talking about a “rural healthcare package” of bills that could be introduced for the 2011 session.
2. A major save on the **rural health tax credit.** Democrats insisted on adding sunsets to virtually all tax credits. Our argument that a sunset weakens the rural health tax credits’ usefulness as a recruiting tool was persuasive. Senators Frank Morse (R-Albany) and Ginny Burdick (D-Portland) came up with an innovative idea that keeps the 2014 sunset but gives a 10-year extension to anyone receiving the credit in 2013, in the unlikely event the credit goes away.
3. **Medicaid expansion.** A greatly expanded hospital tax and new tax on commercial insurance premiums will allow Oregon to cover 80,000 kids and 50,000 low-income adults under the Oregon Health Plan. That expansion, during this recession, is truly remarkable.
4. **Universal health care.** The dream of providing health care coverage for all Oregonians ran into the recession and political realities. Instead, the Legislature took what it thought were important first steps in the process. These include Medicaid expansion and seven bills recommended by the Oregon Health Fund Board dealing with data collection, evidence-based practices and medical homes. The new Oregon Health Policy Board is to make recommendations to the 2011 session for next steps toward universal coverage.
5. **Primary care workforce and reimbursement.** There was a lot of talk during the session about the importance of primary care in controlling health care costs. But ultimately, not much was implemented. Proposals to increase primary care reimbursement, and train more primary care physicians did not fly. On the positive side, the DHS budget includes a budget note instructing DHS to develop new reimbursement models for OHP that emphasize primary care.
6. We did not end up with the **limited licenses for rural physicians** advocated by many hospitals and clinics. Instead, it was replaced by “license by endorsement” allowing the OMB to accept documents from the state where the physician was first licensed to prove medical education, national medical exam scores, and postgraduate training. They say this should speed up the process.
7. Passage of new **telemedicine** guidelines sets out a framework for what types of telehealth procedures would be paid for by insurance. Details still need to be negotiated in contracts with each carrier.

RURAL HEALTH

Rural health loan repayment funding eliminated **FAILED**

This was the big loss of the 2009 legislative session. Since its inception in 1999, the rural health loan repayment program has received \$400,000 per biennium. It's been terribly under-funded (see HB 2632 below), but the funding has been consistent until this year. The Ways and Means co-chairs zeroed out the budget for this program as part of their \$2 billion in cuts to balance the budget.

HB 2581 – Move loan repayment program to Office of Rural Health **FAILED**

The Rural Health Services loan repayment program is no longer a good fit for the Oregon Student Assistance Commission (OSAC). Almost all of OSAC's other programs help students with scholarships while they are in school.

HB 2581 would have moved the program to the Office of Rural Health. Scott Ekblad, director of the Office of Rural Health, says he's talked with foundations that may be interested in supporting the loan repayment program, but not if it is in a state agency, and while OSAC is a state agency, the Office of Rural Health is not.

Ekblad also testified about the need for more health professionals in rural Oregon. In urban Oregon there is one physician for every 327 people, while in rural Oregon the ratio is 1:819.

HB 2581 passed the House Health Committee, the House floor and the Senate Health Committee but got stuck in the Education Subcommittee of Ways and Means. Scott Ekblad did not want the program with no funding and the co-chairs zeroed out the budget for the rural health loan repayment program.

HB 2632 – Increase funding for Rural Health Loan Repayment **FAILED**

Funding for the Rural Health Services loan repayment program has been stuck at \$400,000 per biennium since the program began in 1989. HB 2631 would have increased the funding to \$3 million. We did not expect to receive that increase during the recession, but thought it was important to demonstrate the need.

Oregon competes with other states for young physicians who are interested and willing to work in rural areas. Last year, there was only enough money for four awards: one physician, one dentist, a nurse practitioner and one physician assistant. The state of Washington, our nearest competitor, funds its program at \$9 million per year.

It was no surprise that HB 2632 did not move out of the House Health Committee. However, it was a big surprise and a big setback when the \$400,000 base funding was eliminated.

HB 2067 – Rural health tax credit sunset

Legislators added sunsets to 51 tax credits including the rural health tax credit. This could have been disastrous for rural communities that use the tax credit to recruit new health care professionals. ORHA and the Oregon Academy of Family Physicians teamed up to oppose the new rural health sunset.

We did not succeed in removing the sunset, but Sen. Ginny Burdick (D-Portland) and Sen. Frank Morse (R-Albany) came up with a creative solution. "In the unlikely event the rural health tax credit sunsets," Sen. Burdick said, "anyone who qualified for the credit in 2013 would continue receiving the credit for 10 years as long as they

continue to practice in a rural area.” This 10-year horizon is long enough that the tax credit can still be used for recruiting.

Sen. Morse said, “Certainty for those who make a commitment to practice in rural area is very important.”

HB 2067 groups the sunsets in three blocks: 2012, 2014 and 2016. The Rural Health Tax Credit would sunset in 2014.

Legislators say they want to review each of the tax credits to make sure they are achieving their goals. It’s also an easy way for legislators to raise revenues without having to vote for higher taxes. When a tax credit sunsets, it simply goes away unless legislators take affirmative action to maintain the credit.

SB 12 – Loan tax credit for rural health professionals

FAILED

The bill would have provided a \$12,000 per year tax credit for a physician, physician assistant, dentist, pharmacist or nurse practitioner that works in a medically underserved area and still has qualifying loans.

SB 24 - Telemedicine

Hospitals throughout the state are using two-way video connections with specialists at OHSU and Doernbecker Children’s Hospital to confirm diagnoses and avoid unnecessary transports. Grande Ronde Hospital saved \$74,000 by avoiding three transports in April. PeaceHealth in Eugene saves more than \$6,000 each time it avoids a ground transport to Portland.

SB 24 requires insurers to pay for medically necessary procedures and consults even if they are done using telemedicine.

HB 2435 – Temporary MD license bill changed to license by endorsement

Evidence is piling up about how long it takes for the Oregon Medical Board to license qualified physicians moving to Oregon. In testimony to the Senate Health Care Committee, Holy Rosary Medical Center in Ontario gave one example of a physician assistant who took six months to get licensed in Oregon; three weeks to get licensed in Idaho.

The solution originally proposed in HB 2435 would grant temporary licenses to physicians who were licensed in another state, had a clean practice history and cleared a background check. But concerns were raised about what happens if a red flag pops up after the physician has already begun practicing in Oregon. What happens if they are ultimately denied a license?

The Oregon Medical Board, OMA and the Hospital Association created an alternative plan. License by endorsement would allow the OMB to accept documents from the state where the physician was first licensed to prove medical education, national medical exam scores, and postgraduate training. They say this should speed up the process.

SB 37 – Rural clinic prompt pay

In the future, DMAP will have to pay rural clinics within 45 days for Oregon Health Plan services. Currently, rural clinics receive partial payment for OHP services from the managed care organizations (MCO) but it usually takes 9 to 12 months for them to receive final payment.

There are 50 certified rural health clinics in Oregon. Some — in places such as LaPine, Jordan Valley, Christmas Valley and Halfway — are the only health care

provider in their community. “Many of them are already operating in the red,” Rep. Ron Maurer (R-Grants Pass) testified. “They can’t afford to wait a year to get paid.”

To avoid any fiscal impact on the 2009-11 budget, SB 37 does not take effect until May 2011.

HB 2460 – Rural EMT tax credit

FAILED

This bill would have:

- Expanded the rural EMT tax credit from \$250 to \$500 per year.
- Added eligibility for first responders.
- Redefined rural so areas around Grants Pass and McMinnville would qualify.
- Removed the sunset on the tax credit that is scheduled for January 1, 2011.

Currently, about 450 people qualify for this tax credit.

SB 39 – Cigarette tax for rural health

FAILED

The idea was to take about \$7 million of the existing tobacco tax money and allocate it to help rural health clinics.

The bill would have allowed the Office of Rural Health to use the money for:

1. EMS training,
2. Improvements at isolated rural health clinics and
3. Grants for rural hospitals to replace or remodel their facilities.

The political problem for this bill was that cities, counties and Oregon Health Plan would have lost money if it passed. The bill was in the Ways and Means Committee at the end of the session.

HEALTH CARE REFORM

HB 2009 – Health Authority and OHFB reforms (SB 856)

HB 2009 is an omnibus health care reform bill that centralizes health care planning and policy in a new agency, the Oregon Health Authority, overseen by a new Oregon Health Policy Board. The bill also incorporates all of the legislation recommended by the Oregon Health Fund Board.

Under HB 2009, the new Oregon Health Authority and Oregon Health Policy Board will start out under the umbrella of the Department of Human Services (DHS). They will be spun off in a separate agency in July 2011.

The bill also calls for the Authority and Board to make recommendations to the 2011 Legislative session on a plan for universal coverage, development of an Insurance Exchange, a public health plan option and more.

HB 2009 incorporates most of the proposals introduced by the Oregon Health Fund Board including:

- POLST registry for end-of-life physician orders All-payers, all-claims database
- Statewide information exchange that would allow electronic medical records to be shared among providers (and that qualifies for 9:1 federal matching funds)
- Focus on patient-centered primary care homes
- Standardized forms and processes for administrative simplification
- Public employer purchasing collaborative, and

- Clinical improvement assessment project to promote the use of evidence-based health care.

AOI, the hospital association, and insurance carriers proposed SB 856 as a less expensive version of health care reform that would build on existing efforts and agencies. It was discussed at length in the Senate and resulted in amendments to HB 2009, but ultimately was dropped in favor of the House version.

HB 2116 – Healthy Kids; OHP Expansion; new provider taxes

A greatly expanded tax on hospitals will leverage enough federal funds to cover 50,000 adults and not hurt hospitals in the process. The hospital assessment is eventually returned to them through enhanced reimbursement. So the hospital tax actually works more like a no-interest loan to the state.

The insurance premium tax is a very different story. It's a true tax and though the insurance companies agreed to it, they don't really support it. The one-percent premium tax will be passed on to individuals and employers that purchase commercial insurance or reinsurance (union trusts and large self-insured plans are exempt, though the bill spells out that PEBB must pay the tax even after it goes self-insured).

The insurance tax will cover 80,000 kids (60,000 through OHP; 20,000 through a new subsidized private insurance program). At least \$9 million from the insurance tax will also be used to provide subsidized commercial insurance for families. Some of that will be used for FHIAP though most of it will go to the kids' plan.

Combined, the two taxes will pull down \$1 billion in federal matching funds.

HB 2755 – Reinsurance

DCBS will analyze and study the possibility of creating a public reinsurance pool to help spread the risk for health insurance carriers. This could impact how the high-risk pool and an insurance mandate might work.

New York state uses statewide reinsurance for a plan called Healthy New York, which has helped lower rates while providing insurance for the previously uninsured.

DCBS will report to the 2011 session if a plan looks feasible.

HB 2122 – Cigarette tax for public health

FAILED

Lawmakers considered increasing the tobacco tax by up to 60¢ per pack to fund public health initiatives. The idea was dropped after the federal government raised its cigarette tax by 60¢ a pack. The Oregon Legislature focused on other tax increases instead.

PRIMARY CARE

HB 3418 – OHP primary care home payment bill

The Department of Human Services (DHS) is to develop new payment models to reimburse physicians for providing primary care home services to Oregon Health Plan patients. This bill complements the section of HB 2009 (from **SB 456**) that creates a task force to define and implement primary care homes for the entire population.

Primary care budget note

Tucked away in the Department of Human Services budget is a budget note directing the agency to explore new rate-setting methodologies to “encourage reimbursement for primary care services at levels that fully represent the value of those services.

Bruce Goldberg and the Office of Health Policy and Research (OHPR) are expected to lead the effort. They are to report to the Emergency Board before the end of 2009.

HB 3257 – OHSU \$ for primary care training**FAILED**

The idea was to increase primary care by:

1. Requiring OHSU to use all of the state funding it receives to train primary care physicians, and
2. Requiring hospitals to pay primary care residents 150 percent of the average resident’s salary.

OHSU says it already meets the intent of #1. The state gives OHSU \$2 million each year for Graduate Medical Education. It spends \$50 million on primary care GME.

OHSU also said paying primary care residents more would not create more primary care physicians. All of the primary care residencies are already full. They said the money would be better spent creating more primary care residencies, which OHSU has been trying to do through its regional programs in Eugene and Bend.

HB 3258 – Med Ed loan program for primary care**FAILED**

This would have created a new loan forgiveness program for medical students who choose primary care. The Oregon Student Assistance Commission testified that a loan forgiveness program is not as effective as a loan repayment program.

HB 3259 – Increase OHP primary care reimbursement**FAILED**

This would have required the Oregon Health Plan to pay primary care physicians 150 percent of the Medicare rate. Legislators could not figure out how to pay for this, so it was replaced with a budget note (see “Primary care budget note” above).

OTHER HEALTH CARE**HB 3204 – LAP hygienists**

Hygienists can now qualify for a Limited Access Permit (LAP) license by doing 500 hours of clinical work with an LAP hygienist. In addition, the bill will allow LAP hygienists to serve patients in hospitals, medical offices or clinics including those staffed by nurse practitioners, physician assistants or midwives.

The Oregon Dental Hygiene Association and Oregon Dental Association agreed to work during the interim on the use of anesthesia and temporary restorations by LAP hygienists.

SB 914 – Any willing safety net clinic**FAILED**

This would have required OHP managed care organizations to contract with safety net clinics to provide service. The Oregon Primary Care Association said too often

safety net clinics try to contract for OHP mental health and dental services but are denied.

PEBB to go self-insured

In March, the Public Employees Benefits Board (PEBB) unanimously voted to go self insured in 2010. Providence and Regence told PEBB they could save 10 percent on their premium increase next year if they self-insure.

This step will move 120,000 state workers out of the commercial insurance market. A special provision in HB 2116 will require PEBB to pay the premium tax assessment even after it self-insures.

HB 3022 – Antibiotics for sexual partners

When physicians treat a patient with gonorrhea or Chlamydia they will now be allowed to write a second prescription for antibiotics for the patient's partner, even without seeing the partner. The goal is to break the cycle of re-infection.

SB 506 – Easing prior authorization requirements

FAILED

The OMA says physicians waste too much time trying to determine eligibility and receive prior-authorization for treatments. SB 506 would have required health plans to set up phone or web-based procedures to determine coverage and eligibility.

SB 507 – OMA bill to speed up credentialing

The Oregon Medical Association pushed hard to speed up the insurance company credentialing process for new doctors. Under this bill, insurers would have 90 days, after receiving a complete application by a physician, to make credentialing decisions. SB 507 also allows new physicians to be paid as non-participating providers while they undergo credentialing by insurers.

SB 508 – Limits time for requesting overpayments

This bill sets a two-year limit for health insurers to request refunds for overpayment to physicians. The provisions in the bill were negotiated with the insurance companies, so there was no opposition to the bill.

SB 509 – OMA targets rental panels

FAILED

Physicians say too often discounts they've negotiated with one insurer are passed on to other companies without their consent. This bill would have limited that practice.

Regence said SB 509 would have outlawed its BlueCard program that allows Regence members to pay local rates when traveling. Regence says PEBB members saved nearly \$16 million in 2008 using the BlueCard program.

SB 862 – “Multi-share” reduced benefit plans

Muskegon County, Michigan pioneered the use of limited-benefit, multi-share, community health plans in the 1990s. Multi-share programs target small employers, low-income uninsured employees and their families. When started in 1999 the Muskegon plan cost \$38 per month for adult coverage; in 2008 the cost had risen to only \$49 per month. Eight states now have implemented similar programs.

The community would determine the actual benefits but these plans often include primary and preventive care, inpatient and outpatient services, emergency, basic dental, and prescription coverage. The plans are not traditional insurance because

they do not include all state mandates and are only available in a limited geographic region.

The bill sets a limit of one plan per community and DCBS can approve these plans in only three communities before July 2013.

HB 2726 – Menu labeling in chain restaurants

Multnomah County already requires chain restaurants to print calories on the menu next to prices. HB 2726 takes that program statewide.

The requirement would apply to chains with 15 restaurants nationwide. Oregon has 181 chains with 2843 restaurants. Of those, 132 chains and 600 restaurants are already covered by the Multnomah County ordinance.

The plan had strong public health support as a way to help consumers make informed, healthier choices.

HB 3243 – MD’s can’t drop Medicare patients

FAILED

Some House Democrats took offence at the idea that doctors were dropping patients when they reached 65 and became eligible for Medicare. Statistics as of 2006 show that:

- 22 percent of primary care offices are closed to new Medicare patients
- 24 percent restrict the number of new Medicare patients
- 21 percent are closed to Medicaid and
- 27 percent restrict the number of new Medicaid patients.

The OMA testified that government programs that reimburse below-cost put physicians in an untenable position.

SB 701- Nurse faculty loan repayment fund created

The number of nursing students in Oregon has doubled since 2001, but that has been done with 20 percent more faculty. So the ONA worked hard to increase the number of nurse faculty.

The new nurse faculty loan repayment fund will help nurse faculty repay their graduate school loans. Teachers with a master’s degree could receive up to \$10,000 per year for three years; those with a doctorate could receive up to \$10,000 per year for five years. To qualify, the nurse would have to have a nurse-teaching job in Oregon.

The new program was funded in the final budget bill of the session with \$200,000.

SB 891 & SB 892 – Expand breast cancer screenings

FAILED

These bills addressed the same problem in complementary but different ways. Currently the Breast and Cervical Cancer Program (BCCP) only serves about 7,000 women each year of the 40,000 who are eligible.

SB 892 would have provided funding so they could screen more women. SB 891 would have committed the state to paying for treatment even if a provider who is not part of the state-screening program does the cancer screening.

SB 891 would have cost the state about \$1.5 million that would leverage nearly \$4 million in federal funds. SB 892 would have cost more than \$2.8 million General Fund.

SB 528 – Field burning ban

Field burning opponents presented it as a public health issue and passed a compromise bill by the slimmest of margins.

The bill reduces field burning from 40,000 acres per year to 20,000 in 2009 and zero in 2010. It includes an exception for 15,000 acres on steep slopes in Marion and northern Linn counties.

HB 2192 – Expand OMIP assessment pool**FAILED**

Legislators in the House and Senate know that the high-risk pool would be more stable and the assessment lowered for each payer if the 600,000+ who buy their insurance through union trusts or self-insured plans also paid into the pool. But the same politics that exempted unions and self-insured from the premium tax to fund Healthy Kids are at play in the OMIP assessment.

The unions convinced Democrats that they should not have to pay. Big businesses including Nike, Intel and Les Schwab convinced Republicans that they should not have to pay.

SB 729 – Allows podiatrist to assist in surgery

The Oregon Podiatric Society said current law allows podiatrists to perform surgery but isn't clear whether a podiatrist can assist in surgery. SB 729 would allow them to assist in any surgery under the supervision of a DO or MD.

HEALTH BOARDS**HB 2058 – Standardizes health boards**

This started out as three bills, HB 2056, 2058 & 2059. In the end, the major components of each were melded into one bill.

The bill brings a level of commonality to the health regulatory boards that has not existed in the past. All will serve at the pleasure of the Governor, most members will have three-year terms and boards will now have two public members. This standardization was a high priority for Rep. Mitch Greenlick (D-Portland) who shepherded the bills through the legislative process.

The new law also requires health professionals to report prohibited conduct of another professional to the licensing board.

HB 2345 – Impaired healthcare professionals

The Department of Human Services will be creating a new program for impaired professionals. It will contract with an outside contractor to provide the service.

At least 15 percent of practicing physicians have or have had a substance-abuse problem according to testimony on the bill.

This new program for impaired healthcare professionals will replace any contracts or programs that health boards had in the past.

SB 850 – Adds dentist but not alternative health provider to HSC

The Legislature, with agreement from the Health Services Commission, voted to add a dentist as a permanent member of the commission that deals with hundreds of dental codes on the prioritized list for the Oregon Health Plan.

Efforts to piggyback on the bill and add a “complementary” medicine provider (e.g. acupuncturist, chiropractor, naturopath and so on) fell short.

Rx

SB 355 – Electronic Rx database

This bill sets in motion a process to create an electronic prescription database for Schedule II, III and IV drugs. DHS must create a plan that details the security precautions that will be built into the system. If approved by the February 2010 session, the database would be housed in the Public Health Division of DHS. It would allow physicians, dentists and other prescribers to quickly search online when they suspect a patient is shopping for prescription painkillers.

Pharma gift reporting

FAILED

Legislators had a variety of ideas about how to limit the influence of pharmaceutical manufacturers on physicians. In the end, infighting among Democrats killed all of the proposals.

HB 2376 would have required Pharma to report gifts to the Department of Justice. **HB 2468** would have had the reports go to the Board of Pharmacy. **SB 649** would have required pharmaceutical companies to adopt the Pharma code of conduct. **SB 845** would have prohibited free lunches for staff in a doctor’s office.

All of these bills ultimately failed to pass.

HB 2126 – Rx formulary and prior authorization for OHP

OHP fee-for-service providers will be required to use of the Practitioner-Managed Prescription Drug Plan and receive prior authorization for prescribing off-list.

Mental health drugs are not included in those requirements. Compliance with the Prescription Drug Plan for mental health drugs is voluntary.

The bill will save \$4.4 million General Fund in the 2009-11 biennium.

HB 2535 – Creates voluntary Rx repository

Pharmacies would be allowed to accept unused medications if they were still in sealed packets or containers. Those drugs would then be donated to others who cannot afford the prescription.

Similar programs in other states have been successful, especially with some of the very expensive specialty drugs. The Board of Pharmacy hopes six or seven pharmacies around the state will participate in the program.

HB 3236 – Pharmacists administering vaccines for children 11+

Pharmacists will now be able to administer all vaccines to children 11 and older. Up until now, pharmacists could administer flu shots for children and adults 15 and older and other vaccines to anyone age 18 and older. Pharmacists currently administer 85 percent of the flu shots in Oregon.

Implementation of this bill will be delayed until 2011 so the immunization registry can be updated to allow pharmacists to report to the registry.

HB 2702 – Psychologists’ Rx

Psychologists have been pushing for two sessions to gain prescription-writing privileges for their members who receive additional training. In the last hour of the last day for committee hearings, psychologists and psychiatrists grudgingly agreed to create an interim work group to develop a training program and recommendation for the February 2010 session. The Work Group would include:

- 1 primary care physician
 - 2 psychiatrists (one from OHSU’s faculty)
 - 1 pharmacist
 - 3 psychologists including 2 with a master’s in clinical psychopharmacology.
- The two sides will have to share the cost of a mediator/facilitator.

HB 3235 – Critical access pharmacies***FAILED***

Rural pharmacies proposed a new critical access designation for rural and frontier pharmacies, similar to the designation for rural hospitals. They said this would have applied to about 20 pharmacies in isolated parts of the state. This was to be the first step toward increasing reimbursement for these pharmacies.

SB 327 – Naturopaths’ formulary

Currently, naturopaths can prescribe naturally derived medications approved by the Oregon Board of Naturopathic Examiners’ Formulary Council. SB 327 expands the drugs on their formulary to include synthetically derived medications as well. New drugs would require specific authorization by the council to be added to the formulary.

SB 598 – Rx take back program***FAILED***

Public health and DEQ proposed a pharmaceutical take back program modeled after one in British Columbia. In 2007, British Columbia collected 52,000 pounds of unused drugs. There was a Senate committee hearing but no action on the bill.

SB 605 – Delegating Rx dispensing to staff

This clears up a glitch in the law that required a nurse practitioner to physically hand a filled prescription to the patient. This was especially problematic in clinics where PAs work part-time. The new law authorizes clinic staff to hand out the filled prescriptions.

SB 654 – Mandatory flu shots for health professionals***FAILED***

Health care facilities with more than 25 employees would have been required to provide free annual flu shots for all licensed health professionals. Employees could have opted out by declining the vaccine in writing.

SB 735 – OPDP expansion

This bill will allow the Oregon Prescription Drug Program to expand to all state purchasing groups. It will also allow OPDP to use a Pharmacy Benefit Manager and to set different prices for rural pharmacies.

INSURANCE MANDATES

HB 2589 – Hearing aids for children

There was no opposition to the proposed insurance mandate to cover hearing aids for children. A survey of insurance carriers indicated that this mandate would increase premiums by .07 percent or 70¢ per \$1,000. A number of parents and families presented emotional testimony about the challenges they face when their children can't hear.

Most individual, small group and large group insurance plans do not cover hearing aids for children.

HB 2794 – HPV vaccine

The Public Health Division testified that there are 111 new cases of cervical cancer in Oregon each year and 41 deaths. They said the HPV vaccine is particularly important for those women who might not get regular pap smears.

Testimony indicated that all major insurance companies and the Oregon Health Plan already cover the HPV vaccine. Self-insured plans and labor trusts don't necessarily cover the vaccine, but they are not subject to state mandates, so this bill would not affect them.

HB 3000 – Autism mandate

FAILED

The proposed autism mandate would have required insurance coverage for a specific treatment called applied behavior analysis. Oregon's Health Resources Commission says there is no evidence this treatment is effective. Insurance companies said this would have been a very expensive mandate to implement.

SB 381 – Traumatic brain injury treatment

This mandate requires coverage for medically necessary treatment of traumatic brain injury. Health insurers did not oppose the bill.

SB 679 – Allows cash payments for healthy lifestyles

Lifestyle choices are a major contributor to the cost of health care. SB 679 tries to address that by allowing insurance companies to offer financial incentives to encourage tobacco cessation, weight loss, fitness and nutrition.

The idea is to start small with, for example, a one percent premium refund if people participate in healthy lifestyle programs.

SB 316 – Clinical trials, routine coverage

The bill makes sure that routine care is covered under their health insurance plan while they are going through clinical trials. Insurers and OHSU agreed on compromise language. Neither expects significant increased costs from this bill.

HB 3023 – Expand dependent insurance coverage

FAILED

Young adults are the largest segment of the uninsured in Oregon: 42 percent of 21 to 24 year olds and 32 percent of 25 to 29 year olds lack health insurance. Many of them had insurance but lost it when they aged out of their parents' policies. HB 3023 would have allowed dependent children to stay on their parents' policy until age 30. An estimated 20,000 young adults would have been covered.

MALPRACTICE

SB 311 – State tort cap

In Clarke v. OSHU, the Oregon Supreme Court ruled that the state's \$200,000 limit (\$100,000 for economic damages and \$100,000 for non-economic damages) was inadequate. In the Clarke's malpractice case, the Clarke's were awarded \$12 million in economic damages and \$5 million in non-economic damages.

SB 311 would increase the state tort cap to:

- \$1.5M per claim (increases by \$100K/year to \$2M by 2014)
- \$3M per occurrence (increases by \$200K/year to \$4M by 2014)
- Effective date retroactive to Clarke decision (12/28/07 for state/OHSU)

There would also be no distinction between economic and non-economic damages.

SB 516 – State tort cap for MDs who treat Medicare and Medicaid **FAILED**

This bill would have allowed physicians to register as agents of the state and fall under the umbrella of the state tort claims act to the extent those physicians are treating Medicaid or Medicare patients. Opponents testified that the bill discriminates against the poor and the aged by allowing them to recover less than similarly harmed Oregonians who are not Medicare or Medicaid patients.

HB 2802 – Wrongful death cap **FAILED**

A bill to overturn Hughes v. PeaceHealth and increase Oregon's wrongful death cap from \$500,000 to \$1.5 million lacked the needed votes to pass in the Senate, so leadership never brought it to the floor. The Oregon Medical Association, medical malpractice insurers, and some industry groups opposed the bill saying it would increase malpractice premium rates.

HB 3021 – State tort cap protection for emergency volunteers and hospitals

Hospitals providing services "pursuant to directions from a public body" during an emergency will fall under the state tort cap, even if there is no charge for the services.

HB 2849 – SAIF entering med mal market **FAILED**

The idea was to create a five-member task force to design a SAIF medical malpractice program to be presented to the Legislature in 2011. SAIF expressed reservations saying it did not know if it could offer lower rates, where it would get the needed start-up capital and where to find the needed expertise.

BUDGET

HB 2649 – Higher tax brackets for high income earners

Approximately 40,000 taxpayers who earn more than \$125,000 (single) or \$250,000 (joint) would see their state income tax rates jump to 10.8 and 11 percent under this plan. House Revenue Committee chair Rep. Phil Barnhart (D-Eugene) calls it the Obama plan – No one who earns less than \$250,000 pays more.

The plan would raise \$472 million in the 2009-11 biennium. The highest earners, those with incomes of \$500,000 and up would pay an average of \$15,000 more per year.

A coalition of business groups is working to refer this and the corporate tax measure to the voters.

HB 3405 – Corporate tax hike

New corporate taxes would raise \$261 million in the 2009-11 biennium:

- \$93 million by increasing the minimum tax on C-corporations from \$10 to \$15.
- \$108 million from new marginal tax rates for C-corporations.
- \$18 million from raising the minimum tax on S-corporations from \$10 to \$150.
- \$18 million from a \$150 entity tax on partnership returns.
- \$30 million by increasing from \$50 to \$100 business filing fees with the Secretary of State.

Business groups lined up against the bill saying any tax increase should be temporary.

HB 2069 – Reduces medical deduction for seniors

FAILED

Legislators have struggled all session to find funding for services to seniors. With HB 2069, they think they've found it.

Under current law, seniors are able to deduct from their taxes all of their out-of-pocket medical expenses. This bill would phase out the medical deduction for households with incomes above \$250,000. It would also increase the age of those who qualify from 62 to 65. These two changes would raise \$10 million in the 2009-11 biennium.

HB 2069 would divide these funds. Half would go to Oregon Project Independence (OPI); the other half would go to elderly and disabled transportation.

ORHA's bill tracking Website: <http://www.capitolonramp.com/lts/guests/1477250/>
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