LOBBY OREGON

LEGISLATIVE UPDATE

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HB 2508 – Telehealth Pay Parity

Providers from across the state testified in support of the bill that would require health insurers to reimburse for telemedicine services at the same rate they would reimburse the same service provided in-person.

Dr. Rosemarie Hemmings, a black mental health provider, told the committee that BIPOC Oregonians seeking mental health providers who are also BIPOC have great difficulty in finding a provider. “I get calls regularly from people 2 hours away that are desperate for a BIPOC provider… Tele-mental health allows BIPOC individuals and families another medium to receive care, while mitigating some of the other social determinants of health that they face related to transportation, parking, travel, child care costs, taking time off, as well as the issue around stigma in the black and latino populations.”

Kristen Downey, Providence, says they are a direct provider of telemedicine services. “While the provisions of this bill would result in increased reimbursement for Providence, we are committed to moving forward with value based models, and can’t support adding additional cost to the system without additional value.” Providence proposes narrowing the scope of the bill to a two year pilot, and only for video conferencing and “store and forward” video.

PacificSource and Cambia testified with similar concerns.

Chair Rachel Prusak (D-Tualatin/West Linn) said they will work to find another time to hear more testimony from those who were cutoff due to time.

HB 3036 - PA Modernization

The Oregon Society of Physician Assistants is back this session with a proposal to change how PAs are overseen in Oregon. They say the administrative burden involved with hiring and employing a PA creates barriers to their hiring, resulting in nurse practitioners (who do not have the same supervisory requirements or administrative burden) being hired instead.

Their proposal would:

- Remove requirements for minimum levels of chart review and hours of on-site supervision
- Replace current practice agreement system with “collaboration agreements” that are signed by a physician, a podiatrist or a “clinically experienced PA” with at least 10,000 hours of experience in a specialty area
- Collaboration agreements are kept on file at the PA’s primary place of employment and made to the Oregon Medical Board on request
- Removes the liability tie between a PA and a physician; makes clear that a PA is legally responsible for the care the care they provide

The Trial Lawyers' Association voiced concerns however that putting ultimate legal responsibility on the PA poses potential problems for Oregonians harmed due to medical negligence as there is no clear "standard of care" for PAs.

The Oregon Medical Association said they negotiated a bill in 2020 but that this legislation is significantly different. "Our goal is to ensure that our PAS are getting hired, and that they are working within their scope… We are just making sure that we all have the technical pieces necessary for patient safety, but more importantly so that PAs and physicians understand their roles and the relationship" says Courtni Dresser. They plan to meet further with the proponents to find language that works for everyone.

Sam Barber, on behalf of the Oregon Academy of Family Physicians, voiced concerns that the collaborative agreements created in the bill need more detail to ensure that the level of collaboration is commensurate with a PA's education, competencies and experience. He also pointed out that the bill inadvertently creates independent practice for PAs because it allows two PAs with 10,000 hours of experience to collaborate with each other. He says that more conversation is warranted about what standardization of training is necessary, and how competency is tracked and determined.

Rep. Maxine Dexter (D-Portland), a practicing physician, said "I do think that the supervisory versus collaborative language is really problematic, and that the liability issues are increased for the PAs who also tend to make lower salaries."

SB 65 – Transfers Insurance Exchange and COFA to OHA

The Oregon Health Authority and the Department of Consumer and Business Services are jointly proposing to move the individual insurance marketplace from the Insurance Division in DCBS to the Oregon Health Authority. The marketplace covers roughly 127,000 Oregonians.

"There's no change of policy, no change in staffing structure, nothing like that… Transitioning the Marketplace to OHA would better align policymaking and purchasing power for the state by increasing OHA's ability to spread improved models of care and payment reforms from public programs and PEBB/OEBB products to Marketplace plans" says Pat Allen, OHA Director.

DCBS Director Andrew Stolfi says the bill does not transfer any insurance regulatory functions such as rate review, or the creation of standard bronze, silver and gold tier plans.

Rep. Andrea Salinas (D-Lake Oswego) testified that she hopes transferring the marketplace will help with the potential establishment of a public option health plan.

The Compact of Free Association Premium Assistance Program was established by the legislature in 2016 to provide free health insurance for income citizens of the Marshall Islands, Micronesia, and Palau who live in Oregon under the Compact. The bill also transfers the COFA program to the Oregon Health Authority.

Cambia submitted written testimony in opposition to the bill. They argue that this should not take place in the middle of the pandemic, and that the health insurance exchange should be focused on the special enrollment period that goes through May, rather than moving to a new agency.

SB 70 – Regional Health Equity Coalitions

Regional Health Equity Coalitions (RHEC) are autonomous, community-driven, cross sector groups. The RHEC model works with local communities to identify sustainable policy, system and environmental solutions to increase health equity for communities of

color and other marginalized identities. There are currently six RHECs; SB 70 would expand the model statewide by adding another four.

"The importance of codifying the definition of RHECs is central to this bill. The RHEC model was designed intentionally to ensure that communities most impacted by health inequities were at the forefront of policy, systems and environment change work that impact their communities" says Annie Valtierra-Sanchez from the Southern Oregon Health Equity Coalition.

SB 610 – Psychologist Incentive Fund

Sen. Lew Frederick (D-Portland) is trying to address two issues with SB 610, the dearth of behavioral health professionals in Oregon's workforce, and the inadequacy of cultural competency training for police officers.

The bill as written would provide housing support and loan repayment for psychologists seeking doctoral training. Frederick says that amendments are coming however to expand this to a broader list of behavioral health professionals.

Frederick says the bill would also give preference to psychologists with cultural competency training preference during hiring for positions within the police academy.

SB 640 – Indian Health Scholarship Program

Sen. Bill Hansel (R-Athena) proposes to create a new scholarship program for members of federally recognized tribes who agree to practice at a tribal service sight for at least the number of years they were enrolled in a health profession degree program at Oregon Health and Sciences University.

Robert Duehmig, Interim Director of the Office of Rural Health, updated the Senate Health Committee on the various pipeline programs available in Oregon, as well as the Health Care Provider Incentive Fund. But "more investment is needed to support AI/AN populations through the early pipelines of education." As of 2018, only .3% of active doctors in the United States identified as American Indian or Alaskan Native. "Should the committee choose to move this bill forward, [the Office of Rural Health] is ready to assist in technical amendments to ensure that [this program] is aligned with Oregon's other health incentive programs."

HB 2360 – Public Charge

Rep. Andrea Salinas (D-Lake Oswego) told the House Health Committee that HB 2360 is a "simple but very important bill to help reduce fear, confusion and anxiety in the immigrant community." The same bill passed the House in 2020.

"Public charge" refers to a federal policy implemented in 2019 under former President Trump that allows immigrants to be denied legal residence or citizenship if they receive public benefits such as the Oregon Health Plan. HB 2360 would prevent hospitals from requiring patients to sign up for the OHP before receiving charity care, which ultimately makes immigrants avoid seeking health care, said Rep. Salinas.

SEIU and Providence spoke in support of the bill.

HB 2313 – Inventory of Recovery Services

The House Behavioral Health Committee passed HB 2131, which tasks the Alcohol and Drug Policy Commission with taking an inventory of services available to prevent and treat substance use disorders. The bill was referred to Ways and Means.

SB 169 – Non-Competes

Senate Labor and Business held a public hearing on the -2 amendment to SB 169, which increases the minimum salary paid during a non-compete agreement from $50,000 to $72,000. Sen. Lee Beyer (D-Springfield) said he would prefer to completely outlaw non-competes, but sees the -2 amendment as a "reasonable compromise."

Oregon Business and Industry said it could not support the amendment and asked the committee to move the original bill. Committee Chair Chuck Riley (D-Hillsboro) said he is personally uncomfortable with the bill as originally written, and carried the bill over for the committee to discuss further.

COVID-19 In the Workers' Compensation System

"In June MLAC began to look review and monitor workers comp system and what the impacts of COVID on the system. Specifically, our mission was to determine whether there was an imbalance in the system and if so, what fixes were needed, and if a presumption would fix those imbalances," says Kimberley Wood, who represents management on the Management-Labor Advisory Committee known as MLAC.

The Committee met six times to review data and information about COVID-19 workers' compensation claims, received public testimony, and discussed recommendations for specific changes. That work culminated with six consensus recommendations:

1. DCBS should convene a stakeholder group to discuss removing Social Security numbers from workers' compensation report forms. The Committee heard concerns that the use of SSNs had a chilling effect on workers filing claims.
2. DCBS should develop COVID-19 specific educational materials for employers and workers.
3. They would support the rulemaking discussions conducted by Oregon OSHA relating to communicable disease standards.
4. Express concern about insurers with apparent high denial rates for COVID-19 based claims.
5. Convey support on the proposed rule to remove the impact of COVID-19 claims on employer experience ratings.
6. Forward issues raised regarding public health, paid leave, contact tracing and enforcement of retaliation laws to the responsible enforcement entities.

The Committee was unable however to reach consensus on two proposals—one from labor, and one from management—that deal with other outstanding issues.

Labor proposes a presumption for COVID-19 claims. They say prior to July 16, 2020, SAIF reported 13% of claims denied, relative to 67% by other insurers. "Under the current system, workers bear the burden to prove where they contracted COVID-19. With a virus that does not have instantaneous symptoms and that can be transmitted by an individual who is asymptomatic, this becomes an impossible task for a frontline worker providing essential services to the public," says Diana Winther, the labor Co-Chair of MLAC.

Management says the presumption is too broad, as it would cover any worker who tests positive for COVID, regardless of where the exposure occurred. It is also problematic as eligible workers are largely determined by their industry, not by the actual exposure an employee has on the job to the public or co-workers.

Instead, management supports a rules-based solution to protect workers. Their proposal would ensure that all workers with a positive test receive interim time-loss pay for a 14-day quarantine. If a worker's test came back negative however, that worker could be out of work for 13 days and the insurer would not be required to cover time-

loss. They also support making the rules retroactive to the beginning of the outbreak to allow denied claimants access to the same process and a second review of their claims.

The Committee did not make any indication as to whether they would address this issue in legislation.

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