
LEGISLATIVE UPDATE

Prepared for OAFP

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SB 765 – Primary Care Payment Reform

Sen. Elizabeth Steiner Hayward (D-Portland) told the Senate Health Committee, “We want to encourage primary care providers to offer a complete range of services even if those ancillary providers are not covered by fee-for-service health insurance.”

Dan Paulson, MD, described a new clinic he helped start in Springfield that serves 8,000 Medicaid patients. Trillium, the local CCO, pays an all-inclusive per member per month payment for each of those patients. “This has allowed us to integrate behavioral health, a diabetic educator, pharmacist, embedded dental hygienist, yoga classes for pain patients, and pool memberships for some patients.” He added, “I’m allowed to do the right thing for my patients. I don’t have to think about whether I can link a service to a payment code.”

Contrast that with Liz Powers, MD who runs a clinic in Enterprise. Dr. Powers said last year they billed 150 plans for 130 payers. “None of them cover the support services her clinic provides including a diabetic educator, clinical pharmacist, community health worker, and health coach.” She said what Oregon needs is “a single primary care payment model that emphasizes alternative payment methodology.”

The bill refines the definition of primary care that is used by the Oregon Health Authority when it collects data on the percent of insurance premiums that pays for primary care, and allows the state to set percentage targets for alternative payment methodology reimbursement in primary care.

SB 735 – Hospital & insurance metrics

Kristin Dillon, MD chairs the Health Plan Quality Metrics Committee. “If these metrics are good, they should work for every health insurer,” she told the Senate Health Committee.

Unfortunately, she said, the legislation that established their Committee, SB 440 (2015), has been interpreted to apply only to Oregon Health Authority plans, so CCOs, OEBC and PEBC. Commercial health plans fell outside the committee’s authority.

SB 735 is designed to:

- Expand the committee’s scope to include all commercial health plans.
- Add an oral health representative to the metrics committee.
- Establish a structure for hospital measures that will work across all payers.
- Allow the committee to create a core metrics set that all insurers would have to use, along with a menu of other measures that they could use.

The committee is waiting for new amendments to the bill that will include all of these components.

HB 2014 – Non-Economic Damages Cap

Non-economic damages are awarded to compensate someone for pain, suffering, loss of companionship, or emotional distress caused by someone’s negligence or

abuse. In 2016, an Oregon Supreme Court case limited non-economic damages to \$500,000. This bill would remove that cap.

Sen. Floyd Prozanski (D-Eugene) explained, “What we’re trying to do is get back to the days when the jury decided whether someone was wronged, and that they decide how much is due in damages.”

One woman told the story of how an anesthesiologist had sexually assaulted her while she was under anesthesia. Her PTSD from those events led eventually to her decision to quit her job. Another proponent told the Committee about the years of discrimination he suffered working for Daimler. Though there is not a cap on economic damages, cases such as these do not qualify and thus are limited to \$500,000 in damages.

Opponents of the bill seemed to be aligned in their willingness to remove the cap in cases where the perpetrator was charged with a criminal act. But they distinguished between cases where the perpetrator acted with malice, and cases where the harm was unintentional.

An OB/GYN testified that in her specialty, lawsuits over poor outcomes that are completely out of their control are common. “The majority of our neighbor states have damages caps equal to or lesser than ours,” says Bryan Boeringer, Oregon Medical Association. “Washington, which does not have a cap, has malpractice premiums \$18,000 higher than Oregon’s.” He says that premium increases of that amount could limit access to specialties such as obstetrics and gynecology and increase the cost of health care.

SB 698 – Rx Translations

People who have limited English proficiency are twice as likely to misuse a medication. Emergency room visits and hospitalizations due to avoidable medication errors are expensive. According to a Harvard study, the cost per preventable drug injury is about \$10,375, totaling \$1.2 million per year for a single hospital, say proponents.

The bill would require pharmacies to provide translations on prescription bottles for people with limited English proficiency. The bill is limited to the 10 languages spoken by .2% of Oregon’s population or more. Companies that provide these translations are expected to charge about \$60-70 a month.

Well below half of pharmacies do not provide translation services according to a recent survey conducted by nursing students at OHSU.

“I feel like this is an equity issue and a justice issue, and I want to do it” said Sen. Laurie Monnes Anderson (D-Gresham).

Co-chairs’ Budget Shows Widespread Cuts

Oregon’s economy is expected to generate record revenues in the 2019-21 biennium but the co-chairs of Ways and Means say in order to protect Medicaid and K-12 education, other programs will have to be cut unless additional revenues are found.

Their \$23.7 billion budget would add \$668 million for K-12, which educators blasted as “inadequate”, saying it would result in teacher layoffs and larger class sizes.

The Governor’s Medicaid budget included a \$2 per pack tax on cigarettes and a new tax on businesses whose employees are on the Oregon Health Plan. But neither of those taxes has passed yet, so they are not included in the co-chairs’ budget.

The co-chairs also did not include the \$2 billion in an as-yet-undefined business tax to fund education.

Without those additional revenues, the co-chairs say other state agencies will face cuts of up to 5%. Sen. Betsy Johnson (D-Scappoose), one of the three co-chairs, said, “This budget shows what is feasible given existing resources.”

HB 2303 – Pseudoephedrine

In 2005, Oregon made pseudoephedrine a prescription-only drug because Sudafed can be used as a precursor drug to make meth. The law was very successful. Meth Lab incidents dropped from 600 in 2001 to near zero today.

“What we have now works,” Woodburn Police Chief Jim Ferraris told the House Health Committee. “Why would we want to take a step backwards?”

The proposal, in HB 2303 would allow consumers to buy pseudoephedrine without a prescription but limit and track sales using a system called NPLeX, used in 35 other states.

Rep. Cedric Hayden (R-Cottage Grove) said, “It’s a way to provide people with access to pseudoephedrine and not be one of only two states that require a prescription,”

Rob Bovett, representing a coalition of cities, counties and law enforcement agencies that oppose the bill, said NPLeX doesn’t stop “smurfing” where a meth cook hires a large group to each purchase the legal limit of Sudafed. Bovett says, “A better solution would be making Pseudoephedrine a formulary drug and allow any pharmacist to prescribe and dispense Pseudoephedrine without a doctor’s prescription.”

HB 2498 – Restricts Independent Contractors

Union representatives want to tighten the definition of independent contractors and make them harder to use by Oregon business. Tom Chamberlain, AFL-CIO, said, “There is a fundamental incentive for bad employers to misclassify workers.” Supporters of the bill say employees deserve the protection that comes with being an employee. They said a 2016 Oregon study found 3,657 misclassified workers.

The bill says independent contractors could not provide services that are within the usual course of the company’s business.

Every major business group including Oregon Business and Industries (OBI), the National Federation of Independent Business (NFIB), Associated General Contractors (AGC), Truckers Association, realtors, the hospital association and others oppose the change.

Skip Newbury, Technology Association of Oregon, said the bill would have a “significant negative effect on technology workers, forcing them to relocate to other states.”

HB 2845 – Midwife Mandate

This bill would require insurers to cover midwifery care in the hospital, birth center or home setting performed by all three midwife types: certified nurse midwife, certified naturopathic physician midwife and direct entry midwife.

“Women and not insurance companies should be deciding where they will deliver babies,” a naturopathic physician from Portland told the House Health Committee.

Proponents say insurers would save money because home and center-based births are much less expensive than hospital deliveries.

Insurers oppose the bill citing patient safety. Jennifer Baker, Cambia, said, “This would force us to credential other providers including direct entry midwives.”

Rep. Alyssa Keny-Guyer (D-Portland) worked on this bill during the interim with midwives and insurers but could not reach a consensus.

HB 2339 – Sobering Center Funding

In recent state budgets, the Oregon Health Authority has awarded matching grants to local sobering centers averaging \$332,500 per facility. There are currently five sobering centers in Oregon with two more expected to open this biennium. So OHA is requesting \$2.3 million for 2019-21. OHA anticipates that two more sobering centers will open in 2021-23 as communities realize their value in keeping people who are drunk out of jail.

The House Health Committee approved the bill, sending it to Ways and Means.

HB 2831 – Peer-run respite for mental illness

Advocates say peer-support services can help those struggling with mental illness recover without hospitalization. Sharon Keene told the House Health Committee, “It’s an opportunity to be in a respectful place that gives us dignity and choice while we can actually work on our own healing.”

The bill would create a pilot program with three peer-run respite centers, one each in the Portland metro area, southern and eastern Oregon, at a cost of \$2.25 million. Oregon Health Authority director Pat Allen said the centers would, “Fill a gap in the continuum of care by creating lower cost services.”

Karena Bayruns said she worked at a peer-run mental health agency in Philadelphia. “I learned more about my depression by working alongside peers who modeled personal responsibility for self care, and encouragement and inspiration,” she said. “I realized I wasn’t just a passive pill taker. I could take control of my health.”

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