These minutes contain materials which paraphrase and/or summarize statements made during this session. Only text enclosed in quotation marks

report a speaker's exact words. For complete contents of the proceedings, please refer to the tapes.

SENATE COMMITTEE ON HEALTH INSURANCE AND BIOETHICS

May 9, 1991Hearing Room C 3:00 p.m.Tapes 78-80

MEMBERS PRESENT:Sen. Bob Shoemaker, Chair Sen. Joyce Cohen, Vice-Chair Sen. Jeannette Hamby Sen. Lenn Hannon Sen. Frank Roberts

STAFF PRESENT: Barbara Coombs, Committee Administrator Guadalupe C. Ramirez, Committee Assistant

MEASURES CONSIDERED: SB 787 SB 760 SB 794

These minutes contain materials which paraphrase and/or summarize statements made during this session. Only text enclosed in quotation marks report a speaker's exact words. For complete contents of the proceedings, please refer to the tapes.

TAPE 78, SIDE A

003 CHAIR SHOEMAKER: Called meeting to order at 3:15 p.m.

PUBLIC HEARING ON SB 787. Work Session on SB 787 re-opens on page 7.

text Witnesses: Rick Grazer, Oregon Chapter, American College of Emergency Physicians Ted Falk, Lane, Powell, Spears and Lubersky Law Offices Bruce Bishop, Kaiser Permanente G.G. Goldthwaite, Governor's Commission on Senior Services

003 RICK GRAZER, OREGON ACEP: Submitted and explained testimony (EXHIBIT A). > SB 787 was proposed with the intent of following federal mandate but it is somewhat expanded: In addition to informational facilities for patients, it mandates that forms be made available as well. > Suggested that the organization have a resource mechaniSMin place to assist patients in completing forms. > The federal bill mandates that this information be provided upon admission into the facility. ACEP would like to be able to the extend this to a number of days.

069 TED FALK, LANE, POWELL, SPEARS LUBERSKY LAW OFFICES: Submits and explains testimony (EXHIBIT B): Suggested two minor changes. > They did not include HMO's because they weren't clear about which ones were included.

093 BRUCE BISHOP, KAISER PERMANENTE: Submitted and explained testimony

(EXHIBIT C): > The definition of Health Care Organization (HCO) is sufficient. > Only HMO's participating in Medicaid or Medicare can be mandated by federal law.

115 CHAIR SHOEMAKER: Why shouldn't all HMO's be included? > Is the bill intended to reach only those program that the federal law reaches or is it intended to reach all HCO's?

120 FALK: They were intending to reach only the federally funded program but they did include all hospitals, nursing home and health agencies and some nursing homes don't participate in Medicare or Medicaid.

124 CHAIR SHOEMAKER: Would these nursing homes object to being included?

Senator Hamby arrived at 3:25 p.m.

126 BISHOP: Most Independent Practice (IPA) model HMO, the requirement would apply when there is an admission to the facility that is subject to the requirement. > Since their programs are intgrated, they have access to the same medical records. > They would prefer to do this only once because they have access to the same records. > This might not be applicable to other HMO's.

136 SENATOR ROBERTS: Could Section 3 (EXHIBIT D) be amended to give instruction to how this would apply to an HMO?

140 CHAIR SHOEMAKER: This along with including them in the definitions of Health Care Organization as they have the other organizations.

147 BISHOP: Kaiser Permanente is implementing new policy requiring that forms be provided at the enrollment process. They are concerned with avoiding repetition.

153 CHAIR SHOEMAKER: Could you work on some language during this hearing?

157 SENATOR COHEN: We can adopt some language in concept form and pass it out.

There was further discussion about how the language should be worded to address the concern of not having to repeat the process and also satisfy the requirement proposed by SB 787.

177 CHAIR SHOEMAKER: It is not necessary that these forms be provide at HMO

outpatient clinics."In patient" facility might be the best way to word this.

196 SENATOR COHEN: Asked that they add a (4), into Section 3 to deal with HMO's.

203 G.G. GOLDTHWAITE, CHAIR OF THE GOVERNOR'S COMMISSION ON SENIOR SERVICES: Submits and explains testimony (EXHIBIT E).

Submitted for the record: > Testimony from Ian Timm, Oregon Health Decisions, (EXHIBIT O)

PUBLIC HEARING ON SB 760 Witnesses: Mary Lou Hennrich, Multnomah

County Tom Engle, Benton County Tom Troxel, Clackamas County Vicki Gates, Department of Human Resources Tom Hussey, Kaiser Permanente Jean Atkins, Planned Parenthood of Oregon

235 MARY LOU HENNRICH, MULTNOMAH COUNTY OREGON: Submitted and explained testimony support of SB 760 (EXHIBIT F). Emphasized Section 2 as it pertained to eligibility determination for women and children and their access to medical care.

282 CHAIR SHOEMAKER: This only requires that an agreement be negotiated, correct? > The intent is to provide the best possible care within the county system for women and children and to provide access to the greatest possible resources.

289 HENNRICH: The county health departments are different in size, makeup and how services are delivered as well as their resources at hand. Patterned after what they are doing in the Senior Services Division. > In some counties, the county is doing the eligibility processing and in others, AFS is doing it. This process is worked out between the county and AFS.

298 SENATOR ROBERTS: Per the letter received from John Bussman, Oregon Health Care Cost Containment Advisory Committee: This bill would have the effect of diluting the effectiveness of managed care environment, could you comment on this?

305 HENNRICH: This refers to Sections 5 and 6. The Coalition of Local Health Officials will respond to this. > Their position is somewhat different because they are a capitated provider under OMAP and a county health department.

327 TOM ENGLE, HEALTH ADMINISTRATOR, BENTON COUNTY AND CHAIR, COALITION OF LOCAL HEALTH OFFICIALS: Submits and explains testimony in support of SB 760 (EXHIBIT G). > Upon Chair Shoemaker's request, expands further on (3) of (EXHIBIT G, page 3). > Continues with testimony (EXHIBIT G, page 3).

TAPE 79, SIDE A

007 TOM TROXEL, DIRECTOR, HEALTH FOR CLACKAMAS COUNTY, CONFERENCE OF LOCAL HEALTH OFFICE: Submitted and explained testimony (EXHIBIT H). SB 760 is not a county vs. state issue. > Emphasized partnership arrangement, (EXHIBIT H, pp. 1 - 2) > Section 2 gives counties the opportunity to determine eligibility in their own counties. > Addressed the concerns expressed by DHRAND OMAP. > Section 6 states that some services should be excluded from the capitated program (ie. STD, Family Planning, TB, etc.). Reimbursement should be provided for these services; whether it be provided to a public or private organization. > Some county provided services are not reimbursed because of the way the system is set up. > Section 6 proposes that some services be excluded entirely.

128 VICKI GATES, DEPARTMENT OF HUMAN RESOURCES: Submitted and explained testimony in opposition to SB 760 (EXHIBIT I).

175 CHAIR SHOEMAKER: Even though the final decision is made at the state level, the processing is done at the local level, it results in more people being cleared eligible than if it is done simply at the state level?

179 GATES: The easier eligibility determination, the more likely to achieve positive results. The Clackamas County pilot increase the number of clients served by 50%.

187 SENATOR COHEN: How are you making your determination about how many people are served and what type of services they are receiving?

200 GATES: Figures refer to eligibility increases. > When pregnant women are enrolled, costs will be incurred. > Their intent is to make the committee aware that SB 760 will incur cost. > They have a prioritized outreach effort and target potential revenue to meet the need.

220 SENATOR COHEN: If SB 27 passes, then why don't we want to recruit?

236 GATES: If SB 27 is funded, outreach effort will be provided.

244 SEN. COHEN: If SB 27 is funded, is $35 million enough to fund the potential extra clients that will be brought in by this manner of recruitment?

246 GATES: This depends on how many women and children will be served, but the assumption is that they will have more.

250 SENATOR ROBERTS: How much will SB 27 increase the number of women eligible for prenatal care?

259 GATES: SB 27 will not affect many of the people but one thing that will happen is an expanded outreach and a more simple way of determining eligibility.

270 SENATOR ROBERTS: SB 27 doesn't cover entire group.

278 SENATOR COHEN: They are out there even though we don't recognize that they are.

296 CHAIR SHOEMAKER: Can you address managed care.

299 GATES: Addressed Section 4: they do have a current policy in place.

310 SENATOR HANNON: Why is Clackamas County doing eligibility?

315 GATES: Pilot project in Clackamas County, AFS staff is sharing cost with the county. > The eligibility determination process was shortened.

330 SENATOR HANNON: Clackamas County may not be representative of all other

counties.

340 GATES: It is not unlikely that what occurred in Clackamas County would happen in other counties. > This discussion is not meant to indicate that we don't agree with public policy benefits, but would like that it be recognized so that it doesn't adversely affect non-entitlement programs.

355 SENATOR ROBERTS: If fully funded would you have objections?

358 GATES: No, as long as issues from Section 6 were addressed.

361 SENATOR ROBERTS: Would you feel uncomfortable with assigning responsibility for eligibility determination to counties?

370 GATES: That section indicates that they have some ability to make some determinations there. The key issue is to have eligibility out-stationed and accessible to people. > They would prefer to use AFS staff people who are appropriately trained.

376 SENATOR ROBERTS: So Clackamas County doesn't represent (1) or (3) of Section 2, it only represents (2), correct? There is also the possibility of the state erring of using 1 or 3 and paying the penalty. The issue doesn't have to do with the effectiveness of this bill in terms of making more people eligible and getting them to the care needed which is an objective. The problem is whether or not we can assure that under Section 2, we can meet the federal requirement properly. The other problem has to do with Section 6 to the extent to which that interferes with managed care. How does Section 6 endangers managed care?

406 GATES: Section 6 of SB 760 asks the state to remove certain services from the managed care contract. Concerned with quality control issues.

TAPE 78, SIDE B

006 GATES: They are looking very closely at public health issues like immunizations and STD, to determine the best way to contract. > The type of language that would probably work best is one that makes it clear that the criteria used to evaluate a managed care provider or preference in awarding a contract to that provider would be the evidence of close coordination and working relationship with the county health department.

020 SENATOR COHEN: Could you figure out a way so that some of these cares could be provided by the managed care provider that you have contracts with?

024 GATES: They would be willing to work with the county health departments to suggest some alternative language for Section 6.

026 SENATOR HAMBY: How does the Clackamas County pilot project differ from the Healthy Start that is also a managed care program.

031 GATES: Not sure about the details, there is variation at times. > They are trying to figure out the best way possible to negotiate the contract and at the same time keep enough providers to provide care for Oregonians.

045 SENATOR COHEN: Agreement among the state, the county, the client bank and the health care organization, is preferable and should be reflected in the language proposed. > Section 6 needs to be addressed as soon as possible, probably by next week.

065 SENATOR ROBERTS: There are two significant issues that need to be addressed by Ways and Means: Possible liability with reference to federal penalties if eligibility errors increase. > This can't be assured if AFS trained employees don't do the certification. > In order to increase number of pregnant women to take advantage of this program, the load needs to be reprojected. > Budget considerations should include the possibility of increased number of clients.

086 SENATOR COHEN: Will there be protective language in the bill for those who are involved in the ultimate decision making process.

104 TOM HUSSEY, KAISER PERMANENTE: Explained and submitted testimony in opposition to SB 760 (EXHIBIT J). > Concerned because the bill references "local governments" and doesn't believe that would exclusively mean counties.

148 SENATOR COHEN: Do you have a contract with Clackamas County?

149 HUSSEY: Yes, among others which are not exclusive. Counties have options in who they choose to contract with.

155 SENATOR COHEN: Should AFS eligible people be referred to you?

158 HUSSEY: If they are managed health care eligible, they should be enrolled in one of the choices that clients have available to them. Once enrolled, care should be provided.

163 SENATOR COHEN: Why is Clackamas County providing services when you should be providing it?

166 HUSSEY: If they were referred to us, we would provide the service.

168 SENATOR ROBERTS: The new people are the ones who are eligible but have never applied for services.

There was further discussion about what the process would be for referrals to an HMO and the HMO process at that point.

194 SENATOR COHEN: There should be a way to rewrite Section 6 to facilitate the movement for potential clients into an appropriate service.

220 JEAN ATKINS, PLANNED PARENTHOOD OF OREGON: Submitted and explained testimony (EXHIBIT K). > Opposed to SB 760 there are other agencies that would be appropriate for providing the health care needed. > They would be supportive of legislation that might require that the state not apply for an exemption for the freedom of choice provision currently in Medicaid law. > They would be willing to be involved in the discussion about alternative ways to deal with the issue of who is providing current care in this state.

283 CHAIR SHOEMAKER: Would you like to be on the committee that will discussing Section 6.

287 ATKINS: Agreed to contact the people that have indicated interest in further pursuing the Section 6 issue.

300 CHAIR SHOEMAKER: Suggested that those people get together with Coombs being the lead person. Closed public hearing on SB 760 and opened the work session on SB 787 .

WORK SESSION ON SB 787

330 BRUCE BISHOP, KAISER PERMANENTE: Submitted proposed changes to SB 787-3 (EXHIBIT D).

348 CHAIR SHOEMAKER: Asked about how much time would be given.

347 BISHOP: The time is left vague because it isn't clear under federal law.

360 CHAIR SHOEMAKER: Should the HMO be defined as the others are?

369 BISHOP: The definition of the HMO would be as defined in ORS 750.005. > All HMO's in Oregon would be subject to this requirement.

387 CHAIR SHOEMAKER: Would the HMO's included in ORS 750.005 include those that don't participate in Medicaid/Medicare? > If the concern is to limit SB 760 to those who do participate, then we need to address this aspect in the definition. > There would be a slight limitation on the definition on ORS 750.005.

398 SENATOR COHEN: I would request that this amendment be accepted in a conceptual form and let the administrator negotiate with legislative council to determine whether the whole definition can be put in line 5 or if a Subsection 6 is needed.

411 BISHOP: Gives two more minor amendments (EXHIBIT D, p. 2, line 6 and line 20, delete and put in on line 23).

424 MOTION:SENATOR COHEN moved 787 amendments further amended in conceptual form to dash 3.

VOTE:Hearing no objection, Chair Shoemaker so moved.

TAPE 79, SIDE B

005 MOTION:SENATOR COHEN moved SB 787 as amended to the floor {with a "do pass" recommendation}.

VOTE:In a roll call vote, the motion carried, with all members present voting AYE. Chair Shoemaker will carry the bill.

016 CHAIR SHOEMAKER: Closed work session on SB 787 and opened public hearing on SB 794.

PUBLIC HEARING ON SB 794 Witnesses: Pam Ruona, Senior and Disabled Services Hartzell Cobbs, Health Insurance Association Brian Boe, American Express Keith Skelton, Task Force on Financing Long Term Care Commission Dick Lada, Senior and Disabled Services Tom Irwin, Oregon Consumers Advocate Ruth Shepherd, Task Force on Long Term Care Paco Maribona, Associated Agents Incorporation

024 COOMBS: There are two SB 794 amendments. One has Health Insurance Association of America at the top and SB 794-1 with no heading is from the Long Term Care Financing Task Force and the Insurance Division.

030 PAM RUONA, SENIOR AND DISABLED SERVICES: Met with Hartzell Cobbs, Insurance Group. There were three major areas they couldn't agree on. Consensus: The task force agreed to delete requiring level commissions and expense loads. > Agreed to delete level premiums and to include marketing and advertizing in Section 4 of the original bill. The insurance division would have to provide standards for those two aspects as well. > Agreed to the education for the insurance agents to be required to an endorsement and require continuing education for insurance agents to receive endorsement for selling Medicare supplement insurance policies and long term care policies > Agreed to eliminate

post claim underwriting Third: when person stops paying premium. > Did not agree: Their policy prohibits the sale of limited benefit of long term care insurance, policies and certificates. The HIAA's version does not. > Their version requires inflation protection for all insurance policies. > 30 day grace period provision about Alzheimer's that the grace period could be up to nine months with some penalty. > They don't agree with the Insurance Industry that Section 5 be left as it was. > Section 5 requires insurers to provide nursing home care and we added adult day care and residential care. This part remains in the task force's bill but in the insurance industry version, it has eliminated any changes and wanted to keep current statute language.

112 CHAIR SHOEMAKER: Why should we go with your version?

117 RUONA: Explained why they believe the committee should go with their proposal.

132 SENATOR ROBERTS: This bill recognizes the same thing under the Medicaid long term care. Importance of alternatives is to meet the need of not knowing what will happen in the future. Critical that there isn't an assumption that a more limited concept is adequate.

143 CHAIR SHOEMAKER: This is an issue of affordability.

There was further discussion about alternative programming and cost effectiveness. > The committee agreed that the most important issues at this time were the cost and inflation protection.

226 HARTZELL COBBS, HEALTH INSURANCE ASSOCIATION OF AMERICA: Submits and explains testimony (EXHIBIT L). > The issue of cost arises when more than one or two types of care are introduced. > Makes reference to the policy (EXHIBIT L, pp. 2-11). > Three Activities of Daily Living (ADL) trigger nursing home care. > Three ADL's are not used to trigger home health care, adult day care, respite care, or any of the other operative types of care. > The reason being is that the majority of people requiring different type of care than nursing homes, have 2 ADL's. > Specific reference is made to (EXHIBIT L, pp. 10-11) pertaining to rates. > All benefits are going to be costly. > Almost all policies have the inflation factor as an option, purchasing this would be an option based on individual needs. > This legislation would be removing the options that the consumer now has, which the reason they are opposed to the inflation aspect be mandated.

330 BRIAN BOE, AMERICAN EXPRESS: Agrees with testimony given by Hartzell Cobbs.

340 CHAIR SHOEMAKER: Proposed that they continue with 3 ADL's as the threshold, for entitlement under the policy, but then have an array of facilities rather than just long term nursing home care.

346 COBBS: There is misleading information out there for consumers in terms of the ADL's and what triggers that coverage. > This why 2 ADL's are most often used because of the equity to the consumer > Using 3 ADL's would be cheaper but the policies would be useless.

368 CHAIR SHOEMAKER: Without 3 ADL's they can't be used for nursing home care.

371 COBBS: The 3 ADL's triggers the nursing home, 2 ADL's trigger all the different level of care that are in there.

384 CHAIR SHOEMAKER: If the triggering event were 3 ADL's but then that would allow you to get into whatever facility is most effective, does this make sense?

388 COBBS: It would not affect the cost as much , the problem is at the selling level because the consumer would believe that they were getting coverage for most home health care if not all, for all assisted living which can vary, for all residential care for adult day care, for all respite care.

393 CHAIR SHOEMAKER: Don't your customers make sure they understand what they are buying before they do so? Wouldn't you then be expected to tell them what they are buying explicitly?

402 COBBS: They would be misled by the phrase "home health care", thinking they are covered, not understanding the importance of that third ADL. > Agreed with earlier testimony about them not making changes to Section 5, but Section 5 is not currently in effect, goes into effect 1-1-92 because that was the compromise legislation that the governor's commission on Financing Long Term Health Care, SSD and HIAA and entire insurance industry agreed unanimously on and voted for in the last session. > In this session is that there are major amendments coming in Section 5, changing the essence of the compromise. > Would like to wait to see if the original compromise works.

TAPE 80, SIDE A

018 KEITH SKELTON, CHAIR, TASK FORCE ON FINANCING LONG TERM CARE COMMISSION: > The different options make it possible to serve more people with less cost. > There is no product for long term care right now that he will recommend. > Suggested that if they can't negotiate on Section 5, leave 1992 for Section 5 and for new sections change the date to 1993. > Most important thing in this bill is to require insurance companies to develop the kind of insurance coverage that they have been unwilling to provide so far. > Teacher's Insurance and Annuity Association (TIAA), the monthly premiums are $56 for age 40, $77 for age 50, $152 for age 60, $282 for age 70.

065 CHAIR SHOEMAKER: Are you in agreement to this plan?

066 SKELTON: Yes.

071 CHAIR SHOEMAKER: What about providing 3 ADL's to have the policy cover the full array of care and facilities but have 3 ADL's necessary to be entitled to the benefits of any of those facilities.

075 SKELTON: That is what the bill provides for.

076 CHAIR SHOEMAKER: Clarifies what this would mean for most people.

084 SKELTON: 3 ADL's would protect insurers in areas other than nursing home. > Requires that they genuinely have disability, which is a concern for insurers.

101 SENATOR ROBERTS: Suggested that data be obtained for critical care providers to help them decide what to do.

109 DICK LADD, ADMINISTRATOR SENIOR AND DISABLED SERVICE DIVISION: > Have extensive data on ADL's > The choice of 2 or 3 ADL's is erroneous

because it eliminates many people from service. > Some of their Alzheimer patients have 1 ADL and need minimal care or no other assistance.

123 CHAIR SHOEMAKER: Attempting to find criteria that makes a policy affordable.

128 LADA: Setting ADL criteria is not equitable for people needing these policies in the future. > What should be taken into consideration is the type of ADL the person has. > The rumor that if benefits are provided more people will take advantage of the system is one used by the federal government years ago. > Have proven that this is not the case; they have spent less agregately. > Insurance companies are making the same argument now.

164 TOM IRWIN, OREGON CONSUMERS ADVOCATE: Supports the dash 1 amendments of SB 794. > Comprehensive policy would be the best way to go. Having too many policies only serves to confuse the consumer.

185 RUTH SHEPHERD, VICE CHAIR OF TASK FORCE ON LONG TERM CARE: Submitted and explained testimony (EXHIBIT L). > Without the protections proposed in SB 794, at least half of the long term care consumer policy holders will end up in inappropriate facilities. > This issue will affect middle and upper income brackets. > The problem won't be solved directly for the state unless it is comprehensive and the state paid part of the premiums. > SB 794 would make it possible that more equitable insurance plans be provided for the consumer.

233 PACO MARIBONA, ASSOCIATED AGENTS INCORPORATION: Explained why it is important for consumers to have the freedom to choose from different kinds of long term care policies. > Making it a comprehensive requirement and adding the inflation mandate rather than making them options, will limit the choice because funds are limited for some. > The market is good, they provide alternative care definitions.

304 CHAIR SHOEMAKER: Can you give us some examples of alternative care policies currently available long term care policies that are good products? Share these products with Barbara.

331 MARIBONA: Continues with testimony from (EXHIBIT N).

Submitted for the record: > Testimony from Elaine Day, Department of Finance, (EXHIBIT P)

370 CHAIR SHOEMAKER: Adjourned meeting.

Submitted by: Reviewed by:

Guadalupe C. Ramirez Barbara Coombs AssistantAdministrator

EXHIBIT LOG:

A - Testimony on SB 787 - Rick Grazer - 2 pp. B - Testimony on SB 787 - Ted Falk - 5 pp. C - Testimony on SB 787 - Bruce Bishop - 3 pp. D- Proposed amendments to SB 787 - 3 pp.
E - Testimony on SB 787 - G.G. Goldthwaite - 1 p.
F - Testimony on SB 760 - Mary Lou Hennrich - 5 pp. G - Testimony on SB 760 - Tom Engle - 7 pp. H - Testimony on SB

760 - Troxel - 5 pp. I - Testimony on SB 760 - Vicki Gates - 3 pp.
J - Testimony on SB 760 - Thomas Hussey - 3 pp.
K - Testimony on SB 760 - Jean Atkins - 3 pp. L - Testimony on SB 794 - Hartzell Cobbs - 11 pp. M - Testimony on SB 794 - Ruth Shepherd - 5 pp. N - Testimony on SB 794 - Paco Maribona - 1 p.
O - Testimony on SB 787 - Ian Timm - 3 pp.

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report a speaker's exact words. For complete contents of the proceedings, please refer to the tapes.

SENATE COMMITTEE ON HEALTH INSURANCE AND BIOETHICS

May 9, 1991Hearing Room C 7:30 p.m.Tapes 81 - 82

MEMBERS PRESENT:Sen. Bob Shoemaker, Chair Sen. Joyce Cohen, Vice-Chair Sen. Jeannette Hamby Sen. Lenn Hannon Sen. Frank Roberts

MEMBER EXCUSED: Senators Hamby, Hannon and Roberts

STAFF PRESENT: Barbara Coombs, Committee Administrator Mark Sigel, Committee Assistant

MEASURES CONSIDERED: SB 1077

These minutes contain materials which paraphrase and/or summarize statements made during this session. Only text enclosed in quotation marks report a speaker's exact words. For complete contents of the proceedings, please refer to the tapes.

TAPE 81, SIDE A

PUBLIC HEARING ON SB 1077

Witnesses: Chad Cheriel, Office of Health Policy Ed Patterson, Oregon Hospital Association Scott Gallant, Oregon Medical Association

000 CHAIR SHOEMAKER: Calls meeting to order at 7:30. Submits (EXHIBITS A and B). Exhibit A is SB 1077 hand engrossed and Exhibit B is SB 1077-7.

020 CHAD CHERIEL, OFFICE OF HEALTH POLICY: > Explains major differences between the initial bill and the dash 7 amendments. > The proposed amendments were discussed in more detail to attempt to understand the changes.

073 CHAIR SHOEMAKER: Identifying the appropriate service areas and the desirable capacity levels for each of the facilities, technologies and services listed is needed. > Why are rural hospitals exempted from Type A under the dash 7 amendments?

083 CHERIEL: If state is going to planning on a broad scale basis, which is tied to high cost and high tech services, then there is a question of whether or not anyone should be exempted from the process. > The previous requirement was intended to protect small hospitals from having to go through a certificate of need process.

089 CHAIR SHOEMAKER: Do you think that any Class A hospitals will attempt to access these services without having a sufficient demand within their area?

094 CHERIEL: Refers to a publication the OHP puts out with a list of the Type A and Type B for a sense of the daily average number of beds and their operating performance. > Recommends that instead of tying an exemption to Type A, Type B categories, that the committee look at the average daily census for a specific operational level. > Suggests that they be exempted because of the limited ability in processing the certificate of need application. > They may never even have a need for major technologies and services if they are only serving five patients per day on an average daily basis.

109 SENATOR COHEN: The following questions pertain to (EXHIBIT B, p. 4,). What kind of information can the CN process require at this time? Are there civil penalties now and when are they used?

118 JANA FUSSEL, CERTIFICATE OF NEED COORDINATOR: They have civil penalties for other data collection functions of the office.

122 CHERIEL: They collect patient discharge data from hospitals and financial data from hospitals and others. > National data collection agency supplied data to them: monitoring reports, monthly utilization and financial performance at hospitals.

129 SENATOR COHEN: How would Subsection 4 (EXHIBIT B, p. 4) work differently from the current process?

132 CHERIEL: There are concerns that detail needed would not be accessible. > Recommends that this be left up to the Health Resource Planning Commission for assistance in defining the nature and scope of data.

143 CHAIR SHOEMAKER: Would both Type A's and Type B's be excluded?

145 CHERIEL: In looking at the financial utilization information, there are some type A hospital and a number of Type B hospitals which are doing as well financially as the other hospitals in the state and may be even better on a per bed basis. > Some of them are involved in major capital investments. > Categorical exemption may not be in the best interest, if a more rational planning and service delivery strategy is available.

155 CHAIR SHOEMAKER: What is your suggestion as to where to draw the line?

157 CHERIEL: Hospitals that operate at 5 patients per day or less, have difficulty breaking even financially. This may be an appropriate indicator regardless of the hospital category. > Continues with testimony about the differences between the initial SB 107 7 and the current proposed amendments regarding moratorium which was present because of the fact that CN was scheduled to sunset. > CN will only apply to the listed technologies that are in the dash 7 amendment. > The last section relates to the list of services that are in the dash 7 amendments. > Comments about the two track strategy for CN one dealing with nursing homes and new hospitals which would not have had a sunset provision. The other is technologies and services which would sunset if the committee takes no action. > OHP would like to retain the current

program more or less in tact for new hospital construction or the nursing home section but the services and technology part is what the dash 7 amendments deal with.

191 SENATOR COHEN: Please explain Section 8 from (EXHIBIT B, p. 6).

203 CHERIEL: This pertains to technology and services. The requirement that if major medical equipment exceeds a million dollar price, they are liable for the CN process. Section 8 reduces it to $500,000. If new services are listed on the CN amendment, they have to go through the CN process.

210 CHAIR SHOEMAKER: Where is the hospital and nursing home requirement?

214 FUSSEL: Section 23 of SB 1077 would have deleted. It was changed and they inserted the deletion of the sunset provision.

225 ED PATTERSON, OREGON HOSPITAL ASSOCIATION OF HOSPITALS: Opposed to SB 107 7. > Problem with the Certificate of Need is that the agency which processes the CN fees causes the agency to become dependent on those fees. > The funding of the agency directs the policy decisions. > Prior to the 1989, rural hospital's were exempted from the CN process. During the conference committee, the rural hospitals were put back again as part of the compromise because of the sunset provision. > Measuring census by an in-patient count is not adequate. > Suggests that all Type A and rural hospitals be exempted. > A draft of the total capital expenditures report (TCE) indicates that in 199 0 the TCE for all hospitals is about half of what it was in 1989. > TCE's for Type A & B hospitals is about 11% of capital expenditures in Oregon. > To increase the small hospital's cost by adding additional fee structures to abide by every time they made a change wouldn't improve the rural health care that is provided. > Suggests that if CN is going to continue, the 31 hospitals under 50 beds be exempt from this requirement. > If an extension of CN is needed, it should apply to the more metropolitan areas where the problem of large capital expenditures exists.

326 There was further discussion about unanswered questions and the need for further testimony and the committee agreed to hear SB 1077 again on Tuesday. > The committee asked for opinions about who should be covered.

369 SCOTT GALLANT, OREGON MEDICAL ASSOCIATION: The dash 7 amendments are broad in terms of granting access to information. > It is an open-ended approach to data collection, to confidential information about patients, peer review, and any number of activities that hospitals participate in. > It would probably would be better to create an entity that could analyze trends in the market place. > Explains why analyzing the market place might be more useful than the regulatory approach.

TAPE 82, SIDE A

024 GALLANT: Continues with testimony. 3% of medical inflation rate is associated with new technology. The larger portions of the increase in medical inflation had to do with personnel cost. > The studies on the clinical outcomes of a facility (EXHIBIT B, p. 3) have been criticized for accuracy and for significance to the public. > This enables the commission to recommend additions or substraction to the list which may be an appropriate role. > The list is basically the same one provided to the committee from the original bill. Subsections on page 5, lines 22 - 30 and lines 1 - 12 refer to new medical services as defined in

Subsection 29 of this section.

103 KIM DANISH, OREGON HEALTH CARE ASSOCIATION: > Presenting a technical clarification presented by the Office of Health Policy (OHP). Submits and explains proposed changes (EXHIBIT C). These are the only concerns they have with SB 1077.

131 CHRIS O'NEILL, DIRECTOR, ADDICTIONS TREATMENT ASSOCIATION: Submits and explains testimony (EXHIBIT D). They are neither for nor against SB 107 7 currently. > They will return with a more firm position. > Testifies specifically to patient care management (EXHIBIT D, pg. 3). > Leaning toward being in favor of the bill.

187 STEVE TELFER, LEGACY HEALTH SYSTEM: With regard to Section 8 (EXHIBIT B, pg 6): The problem is that it seems that the bill proposed that data be collected simply for the purpose of collecting data. > Applying a continuation of the CN is not going to address the problems. > If a list is going to be used for the next two years while a system is being developed, it should be narrow and pertinent and not so concerned with the cost. > Should make use of the resources that are available to help decide what is feasible.

284 SENATOR COHEN: Could you prepare a general listing to assist in determining what is best.

300 LOIS DAVIS, OREGON HEALTH SCIENCES UNIVERSITY: Agrees with Telfer's testimony. They support a CN but of a different nature, one which is limited to actual high cost kinds of services and one that is kept limited. > Has concerns with the threshold because it focusses the attention on the wrong things. > Supportive of looking at outcome based information. > Will return with more comprehensive comments.

320 CHAIR SHOEMAKER: Suggests that Davis and others reach a consensus among

themselves before testimony is presented.

> Adjourned the meeting.

Submitted by: Reviewed by:

Guadalupe C. Ramirez Barbara Coombs AssistantAdministrator

EXHIBIT LOG:

A - Hand Engrossed SB 1077 - 21 pp. B - Proposed Amendments to SB 1077-7 - staff - 9 pp. C - Proposed Amendments to SB 1077 - Danish - 1 p. D - Testimony on SB 1077 - O'Neill - 4 pp.