CR Sent 4-29-88

THE AIDS EPIDEMIC

POLICY RECOMMENDATIONS FOR OREGON'S RESPONSE

Presented by
V/AIDS Policy Committee

obie
S Policy Committee

Kathleen Stout, J.D.
Editor — Wordsmith

February 1, 1987

THE AIDS EPIDEMIC:
POLICY RECOMMENDATIONS FOR OREGON'S RESPONSE

Presented by
the HIV/AIDS Policy Committee

Kristine M. Gebbie
Chair, HIV/AIDS Policy Committee

Kathleen Stout, J.D.
Editor--Wordsmith

February 1, 1987

TABLE OF CONTENTS

OVERVIEW

There is an epidemic in Oregon. It is costly, it is fatal and it grows rapidly. It can kill infants, children, adolescents and adults. In the killing, it does not discriminate between rich and poor, healthy and unhealthy. men and women, heterosexual and homosexual. There is no vaccine to prevent it. There is no cure for it. It is AIDS (Acquired Immune Deficiency Syndrome).[1]

HIV (Human Immunodeficiency Virus) infection[1] is a medical condition. It may result in AIDS, a fatal communicable disease. Experts estimate that up to 12,000 persons in this state are currently HIV infected, and the number is increasing. Between one quarter and one half of these people will develop AIDS within the next five to ten years. For the balance of those infected, the prognosis is uncertain. Some or all of them may subsequently develop either ARC (AIDS Related Complex)[1] or AIDS. The uncertainty results from the fact that AIDS has only been recognized in the United States during the last five years.

Currently in Oregon the number of AIDS cases doubles approximately every nine months. Faced with this escalating health crisis, the Oregon HIV/AIDS Policy Committee convened to develop a coordinated State policy to stop the epidemic, a policy that is responsive to the needs of both HIV infected and non-infected citizens.

The Committee recognizes the fear and stigma currently attached to AIDS. In identifying and formulating both the issues and recommendations, this report seeks to address them in a responsible manner.

This final report arose from a group process in public meetings. The Committee also elicited comments from a wide range of groups. The Recommendations represent the consensus of the Committee unless it is otherwise specified.

The $22,754,982 total budget recommendations for the 1987-89 biennium fund response measures in five areas. Prevention Measures total $2,343,982 with $1,065,549 for Public Health and $1,278,433 for Education. $20,406,000 will fund the necessary Support Services. Coordination measures will require $5,000. No funds are necessary to implement either Insurance and Access to Care Measures or Rights Protection Measures. These budget recommendations reflect anticipated program costs for state agencies, including subcontracts.

In light of the urgent nature of AIDS/HIV infection in Oregon, the HIV/AIDS Policy Committee strongly urges the adoption of these Recommendations, as it respectfully submits them to the Governor and Legislature for policy and funding action.

[1] See pages 11 and 12 under "Clinical Progression" for definitions of AIDS, ARC and HIV infection.

CHARGE TO THE COMMITTEE

In January 1986 the Emergency Board of the Oregon Legislature instructed the State Department of Human Resources to establish a statewide HIV/AIDS Policy Committee. The Committee's purpose is to examine the epidemic of HIV, ARC and AIDS in the Oregon context. Attendant to the general goal of establishing a responsible, responsive and effective statewide policy, specific charges to the Committee include:

- Identifying the current and projected scope of HIV infection and AIDS within Oregon
- Identifying Oregon's current governmental and community agency response mechanisms to HIV, ARC and AIDS
- Recommending the scope and level of services necessary to (1) prevent the spread of the HIV infection and (2) care for people diagnosed as having AIDS or ARC
- Recommending budget appropriations, legislation and state agency actions appropriate to support the identified necessary services.

IN RESPONSE TO THEIR LEGISLATIVE CHARGE:

Carl Berggren, M.A., C.R.C.
Mid-Oregon AIDS Health Education
Support Services, Inc.

Holly Berman /bw/
Holly Berman, M.S.W.
Senior Services Division

Jack Bush
Jack Bush, Ph.D.
Correctional Treatment Program
Mental Health Division

Darrel DuBois /bw/
Darrel DuBois, Person With ARC

Patricia A. Ellis
Pat Ellis, Department of Education
Special Education & Services Division

Marge Erwin, RN BSN
Marge Erwin, R.N., Kaiser Permanente
Representing A.F.L.-C.I.O.

Ted C. Falk
Ted Falk, J.D., Ph.D.
Health Care Attorney
Spears, Lubersky, Campbell, Bledsoe
Anderson and Young

Michael J. Garland
Michael Garland, Ph.D.
Dept. Public Health & Preventive Medicine
Oregon Health Sciences University
Oregon Health Decisions

Kristine M. Gebbie
Kristine M. Gebbie, R.N., M.N., CHAIR
Health Division

George G. Goldthwaite
George G. Goldthwaite
Oregon Public Health Advisory Board

Richard H. Grant
Richard Grant, State Health
Planning and Development Agency

Edward Hendricks, MD /bw/
Edward Hendricks, M.D., M.P.H.
Adult and Family Services Division

Catherine M. Knox
Catherine Knox
Corrections Division

Thomas Koberstein
Thomas Koberstein
Cascade AIDS Project
Ecumenical Ministries

Vicky Koenig
Vicky Koenig, R.N., M.P.H.
Portland VA Medical Center
Representing Oregon Assoc. for Home Care

J. Jeffrey Kushner
Jeffrey Kushner
Office of Alcohol and Drug Abuse

Sherral Landsiedel
Sherral Landsiedel, R.N., B.S.N.
Lane County Health Services
Representing Oregon Nurses Association

Robert Lawrence
Robert Lawrence, M.D., Kaiser Permanente
Immune Deficiency Clinic
Representing Oregon AIDS Task Force

Mark Loveless MD
Mark Loveless, M.D.
Northwestern Univ. Medical School, 1975
Board Certified Internal Medicine, 1980
Board Certified Infectious Disease, 1980
Representing Oregon Medical Association

Charles P. Schade, M.D.
Multnomah County Health Officer
Representing Conference of Local
Health Officials

Gretchen Miller
University of Oregon Law School
Representing Willamette AIDS
Resource Council

*

Wayne Sepeda, Person With AIDS

John Munro
Government Affairs Council
Representing Assoc. Oregon Industries

Paul Starr, M.S.W.
Cascade AIDS Project

Gary Oxman, M.D.
Multnomah Co. Dept. of Human Services
Health Services Division

Cathy Turner, F.S.A.
Insurance Division

Tia Plympton, M.S.W.
Cascade AIDS Project

Thomas Ward, M.D.
Associate Professor of Medicine
Oregon Health Sciences University
Associate Chief of Staff for Education
Chief, Infectious Diseases Section
Portland VA Medical Center
Oregon AIDS Task Force

Sue Sakai, M.S.W.
Good Samaritan Hospital
Representing Oregon Assoc. of Hospitals

James Sampson, M.D.
Good Samaritan Hospital
Representing Oregon AIDS Task Force

Peggy Zach, R.N., B.S.
Benedictine Nursing Center
Representing Long Term Care Institutions

*Mr. Sepeda participated in the work of this committee until his death Jan. 16, 1987.

The following persons have participated in Committee meetings, but are not official Committee members:

- Dan Barker, Office of Drug and Alcohol Abuse
- David Fleming, M.D., Health Division
- Laurence Foster, M.D., Health Division
- Tom Jovick, Ph.D., Adult and Family Services Division
- Brown McDonald, Cascade AIDS Project
- Bonnie Widerburg, Health Division, Secretary to the Committee
- Lester Wright, M.D., Health Division

SUMMARY OF RECOMMENDATIONS

The following alphabetical listing of Recommendations identifies the body responsible for implementation, the necessary action and the budget appropriation required. "Action Required" refers to actions necessary upon submission of the Report. The appropriation figures do not include state costs for promulgating rules, enacting statutes or other administrative duties. As estimates, the figures do not reflect exact calculations of the personal service components as computed by ABIS/PICS systems. These figures do not reflect costs for the private sector.

RECOMMENDATION	RESPONSIBLE BODY	ACTION REQUIRED	APPROPRIATION REQUIRED
Access to Care (Page 60)	◎Health Division	◎Initiate complaint resolution process	$ 0
	◎Professional associations	◎Participate in complaint resolution process	$ 0
	◎Health Division	◎Educate health care practitioners	$ 0
	◎Professional associations	◎Educate health care practitioners	$ 0
	◎Bureau of Labor and Industries	◎OAR re: health care practitioners	$ 0
Adult and Family Services Procedures (Page 74)	◎Adult and Family Services	◎Modify policies and procedures re: intake and recertification ◎Maintain privacy and confidentiality policies	$ 0
AIDS Education Coordinating Committee (Page 52)	◎Health Division	◎Appoint Committee ◎Meeting costs	$ 0 $ 9,000
Blood Testing-Employment (Page 64)	◎Health Division ◎Bureau of Labor and Industries	◎OAR re: occupations ◎Clarify policy re: physical examination rules	$ 0 $ 0
Case Management Contracts (Page 72)	◎DHR-Director's Office	◎Review operations	$ 0
		◎Initiate case management service contracts	$3,600,000
Citizens' Representative (Page 78)	◎Citizens' Representative	◎Provide information, referral, evaluation and advocacy services	$ 0
Communicable Disease Statutes (Page 27)	◎Legislature	◎Repeal Venereal Disease statute (ORS 434) ◎Adopt amended Communicable Disease statute (ORS 433)	$ 0 $ 0

Condoms (Page 43)	⊙County Health Departments	⊙Educate and distribute	$	50,000
	⊙Public and private health care practitioners	⊙Educate	$	0
	⊙Private sector businesses	⊙Increase availability	$	0
Confidentiality of Records (Page 66)	⊙Legislature	⊙Adopt confidentiality statute	$	0
	⊙Public and private health and social service agencies	⊙Adopt and comply with similar confidentiality policies	$	0
Contact Notification (Page 35)	⊙Health Division	⊙Promulgate OAR re: procedures	$	0
		⊙Develop information packet	$	*
	⊙County Health Dept.	⊙Comply with OAR	$	0
	⊙Public & private health care practitioners	⊙Comply with OAR		
Dental Care Through Adult and Family Services (Page 76)	⊙Adult and Family Services	⊙Clarify and distribute policies re: dental payments and emergency conditions	$	6,000
	⊙Professional organizations, health care practitioners and community agencies	⊙Educate	$	0
Discrimination in Housing and Public Accommodations (Page 69)	⊙Bureau of Labor and Industries	⊙Identify public accommodations	$	0
Employment Discrimination (Page 68)	⊙Bureau of Labor and Industries	⊙Continue policy	$	0
Health and Life Insurance (Page 54)	⊙Legislature	⊙Enact statute re: HIV/ARC/AIDS screening, group health insurance	$	0
	⊙Insurance Commissioner	⊙Promulgate OAR re: limits on HIV/ARC/AIDS screening, individual health insurance and medical-lifestyle questions	$	0
	⊙HIV/AIDS Policy Committee	⊙Submit further insurance recommendations to Legislature	$	0
	⊙HIV/AIDS Policy Committee-Insurance Subcommittee	⊙Submit further insurance recommendations to full Committee	$	0

*Integrated into Preventive Services Budget, page 10. For detail see page 38.

HIV/AIDS Policy Committee (Page 80)	●DHR ●Health Division	●Extend Committee term ●Convene Committee ●Provide support staff and services ●Furnish Committee with monitoring reports	$ $ $	0 5,000 0
Informed Consent to Blood Testing (Page 62)	●Legislature ●Health Division	●Enact statute re: Informed Consent to HIV testing and Health Division OAR authority ●Promulgate OAR re: testing requirements, procedures and exceptions	$ $	0 0
Insurance Risk Pool (Page 58)	●Legislature ●HIV/AIDS Policy Committee ●HIV/AIDS Policy Committee-Insurance Subcommittee	●Enact legislation re: risk pool or similar mechanism ●Convene interim task force if necessary ●Submit Risk Pool Recommendations to Legislature ●Submit Risk Pool Recommendations to full Committee	$ $ $ $	0 0 0 0
Quarantine (Page 40)	●Legislature ●Health Division	●Adopt amended Communicable Disease Statute (ORS 433) ●Promulgate OAR re:quarantine	$ $	0 0
Regulating Risk Sites (Page 44)	●Legislature ●Public health officials ●Health Division	●Adopt amended Communicable Disease statute ●Adopt policy ●Provide information	$ $ $	0 0 **
Reporting (Page 29)	●Health Division ●Public & private health care practitioners	●Promulgate OAR re: anonymous reporting of ARC and asymptomatic HIV infection ●Initiate and distribute reporting forms ●Prepare and distribute educational materials for patients ●Amend OAR re: laboratory procedures ●Comply with OAR ●Provide education and counseling	$ $ $ $ $	0 * * 0 *
Schools (Page 47)	●Health Division ●County health departments, public & private schools	●Amend School Guidelines ●Adopt Guidelines	$ $	0 0

*Integrated into Preventive Services Budget, page 10. For detail see page 38.
**Reflected into Target Group Education Recommendation.

Syringes/Needles (Page 45)	•State and local, public and private drug abuse agencies	•Educate clients •Promote availability	$ 0 $ 0
	•Health Division	•Research and report •Promote availability •Coordinate with pharmacists' organization for education	$ 12,000 $ 0 $ 0
	•Professional pharmacy organizations	•Coordinate with pharmacy organizations for information packets, educate members	$ 0
Target Group Education (Page 49)	•Health Division	•Educate high risk individuals •Contract to community agencies for high risk groups other than drug abusers •Provide materials and staff for general education and target group education of potential high risk groups, service providers and low risk groups; educate county AIDS trainers	$ * $ 300,000 $ 560,583
	•County Health Departments	•Educate high risk individuals •Provide staff for general education and targeted group education of potential high risk groups, service providers and low risk groups	$ * $ 375,850
	•Alcohol and Drug Program	•Contract to community agencies for education of drug abusers	$ 33,000
Treatment Expense Funding (Page 70)	•Legislature	•Allocate funding to Department of Human Resources for distribution to Adult and Family Services Division and Senior Services Division	$16,800,000
	•Adult and Family Services Division & Senior Services Division	•Administer medical and support service funds	$ 0
Preventive Services Budget (Pages 38-39)			$ 1,003,549
		TOTAL	$22,754,982

*Integrated into Preventive Services Budget. For detail see page 38.

BACKGROUND

Definitions and History of the Epidemic

In 1981 AIDS was first recognized in the United States. The U.S. Centers for Disease Control (CDC) began keeping statistics on the incidence of AIDS that year. The disease is now reportable in all 50 states.

In 1984 researchers discovered the agent believed to cause AIDS. It is a virus called HIV (human immunodeficiency virus). Other names for this virus are HTLV-III (human T-lymphotropic virus type III), LAV (lymphadenopathy-associated virus), or simply the AIDS virus.

Modes of Transmission

Current research demonstrates that HIV infection spreads in three situations. First, sexual contact with an infected person may transmit the infection. Risk of infection increases if certain unsafe sexual practices occur. Such practices may include: anal, oral or vaginal intercourse without using a condom, acts resulting in blood or urine in the mouth or any blood exchange, and sharing sex toys. Second, HIV infection may be transmitted through contaminated blood or blood products, including shared use of needles and syringes. Third, an HIV infected mother may transmit the infection to the fetus, newborn or nursing infant.

There is no evidence for other mechanisms of spread, including transfer by a biting insect vector, saliva or simple casual contact with an infected person. There is excellent evidence that such mechanisms are not involved in the spread of AIDS.

Persons at Risk

Men who have engaged in male to male sexual contact without observing safe sex practices are at high risk of HIV infection. Persons who have shared needles and syringes, used intravenously, are at a similar high risk of infection. The number of Oregonians at risk as a result of these behaviors is unknown, but expected to be large. Hemophiliacs are a small group of Oregonians at very high risk of already being infected with HIV.

Heterosexual men and women who have sexual contact with multiple partners without using safer sex practices face a growing risk of HIV infection. This group is expected to be even larger than those currently at high risk.

Clinical Progression

HIV may infect several different types of cells, especially T helper lymphocytes, one of the cells of the body's immune system. Infection may result in a decrease in the numbers of these lymphocytes, making the individual susceptible to certain infections and cancers. Infection is for life, and all infected persons are presumed to be capable of transmitting the virus to others.

Persons infected with HIV exhibit a spectrum of clinical conditions. When initially exposed to the virus, persons may experience an acute flu-like illness which lasts for up to two weeks and then spontaneously resolves. Once infected, a person may be totally free of symptoms for months or years. The mean incubation period may be at least five years. In one case the incubation period was at least eight years. The outer limits of the period has not been definitively determined.

Ultimately, a large percentage of infected persons suffer medical consequences from the HIV infection. ARC refers to those illnesses other than AIDS caused by HIV infection. The illnesses do not include the specific infections or cancers seen in AIDS. The symptoms may, however, include persistent weight loss, severe fatigue, fevers, diarrhea and/or yeast infections. ARC patients may continue to deteriorate and develop AIDS. AIDS is a severe disease of the immune system in which the immune system's capability of responding to infections or tumors is drastically reduced. The infections or tumors that people with this disease acquire are not ones to which people with normal immune systems are susceptible. The CDC estimates that 25 to 50 percent of persons infected with HIV will develop AIDS within 5 to 10 years after becoming infected. Experts do not know what effect the HIV infection will have on the remaining 50 to 75 percent of the infected persons after the initial five to ten year period.

To date, AIDS has been nearly uniformly fatal. Most patients die within two years of diagnosis. At present, there is neither a cure nor a vaccine. Prevention is the only available method to stop the spread of the AIDS epidemic.

HIV Screening

Process The HIV antibody tests identify HIV exposure and presumed infection. These tests, which do not directly demonstrate the presence of the virus, may involve several separate tests. The first, called the ELISA test, is inexpensive, rapid, and highly accurate, especially for persons in high risk groups. Repeat testing on the same sample confirms an initially positive ELISA test. If this sample is repeatedly reactive, the results may be corroborated by a second, independent test called the immunofluorescence test (IFA). The Western Blot is another test used for corroboration. Only the samples found to be positive using the corroborative test following the multiple ELISA tests are classified as positive.

Reliability The reliability of ELISA and IFA test procedures is high but depends on the timing of the test and the population being screened. Test results during the first few weeks after infection may not be reliable. It is thought to take approximately six to twelve weeks after infection for the body to develop high enough levels of antibodies for the antibody test to be positive. The infected person can infect others during this time.

In general, the higher the prevalence of infection in a group, the greater is the predictive value of a positive test result. The process is considered better than 99 percent accurate for identifying infected persons from groups at high risk with a history of one or more of the following risk behaviors:

- male to male sexual contact without observing safer sex practices
- intravenous drug use
- injectable blood product use (hemophilia)
- sexual contact with persons at risk, including prostitutes.

The process is much less accurate for those who are not at high risk of infection. Thus, extra tests may be required to confirm and corroborate a positive result on the blood of a person not in a high risk group. See Appendix, page 83 for an explanation of the difference in high risk vs. low risk populations.

Costs of Diagnosis

The cost for HIV testing procedure, including the extensive pre- and post-test counseling, averages $40 per patient. The initial diagnosis cost for ARC averages several hundred dollars. The cost of an AIDS diagnosis is even higher and dependent upon the range and sophistication of the diagnostic procedures required.

Cost of Treatment

Early in the epidemic, the CDC estimated that in 1984, the average charges for hospital care, per AIDS patient, was $147,000. This was based on the first 10,000 AIDS patients in the United States. This estimate did not include the costs of outpatient care and support services.

More recently, the California Department of Health Services estimated the average charges in 1984 for hospital care per California AIDS patient, was $67,340. The total estimated medical costs including outpatient medical treatment, but not support services, was $91,000.

Most recently researchers from the Palo Alto (California) Medical Foundation and the Institute for Health Policy Studies, University of California at San Francisco, estimated the national average of hospital charges for AIDS patients based on 1984 costs. They ranged between $60,000 and 100,000 and were most likely between $60,000 and $75,000. They did not estimate the additional cost for outpatient medical care or support services.

In Oregon, the Kaiser Permanente Immune Deficiency Clinic is the only agency which has developed cost of treatment information. Based on 12 patients treated at Kaiser Permanente from early 1984 through January 1985, the Clinic estimated that hospital, outpatient charges, and supportive service costs were approximately $52,000. This figure represents actual hospital and outpatient services at Kaiser Permanente, with charges reflecting those at community hospitals in 1984. The supportive services cost estimates were based on information provided by agencies serving those 12 AIDS patients in 1984.

For the purposes of this report, $50,000 per Oregon AIDS patient is the total estimated cost for the 1987-1989 biennium. It includes state payment costs for hospital and outpatient charges, supportive service costs and the effect of drugs becoming available which prolong the lives of AIDS patients. This estimate should decrease if nursing homes, hospices and home care settings are more readily available to AIDS patients.

Long Term Prognosis

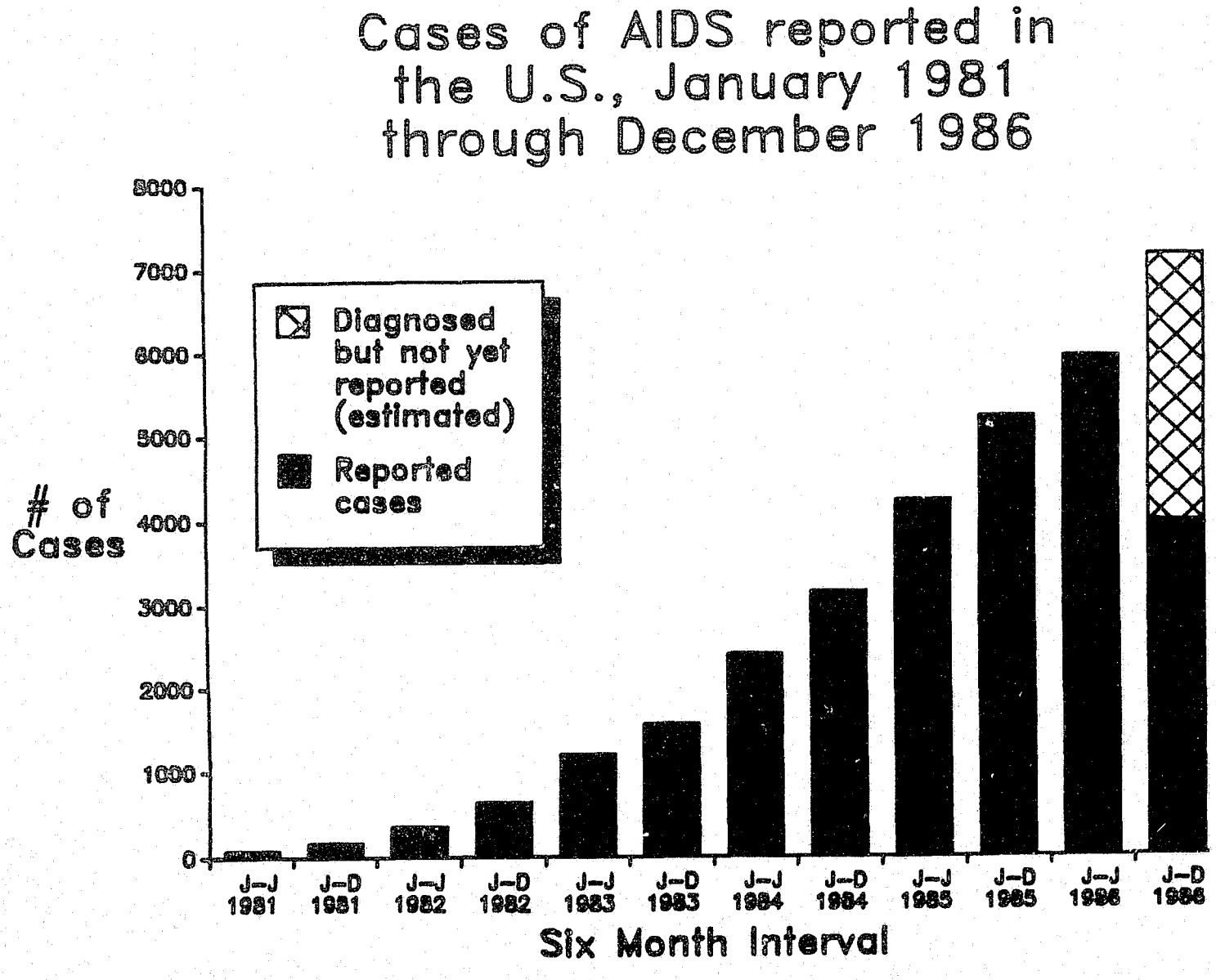
The long term prognosis for infected persons who are as yet asymptomatic remains unknown. The CDC estimates that 25 to 50 percent of persons currently HIV infected will develop AIDS within approximately five to ten years. For ARC patients, an even greater percentage is expected to continue to deteriorate and develop AIDS. For AIDS patients, the outlook continues to be grim.
To date, CDC has not reported a recovery from AIDS. However, experts anticipate eventual development of both a vaccine and an effective treatment.

SCOPE OF THE EPIDEMIC

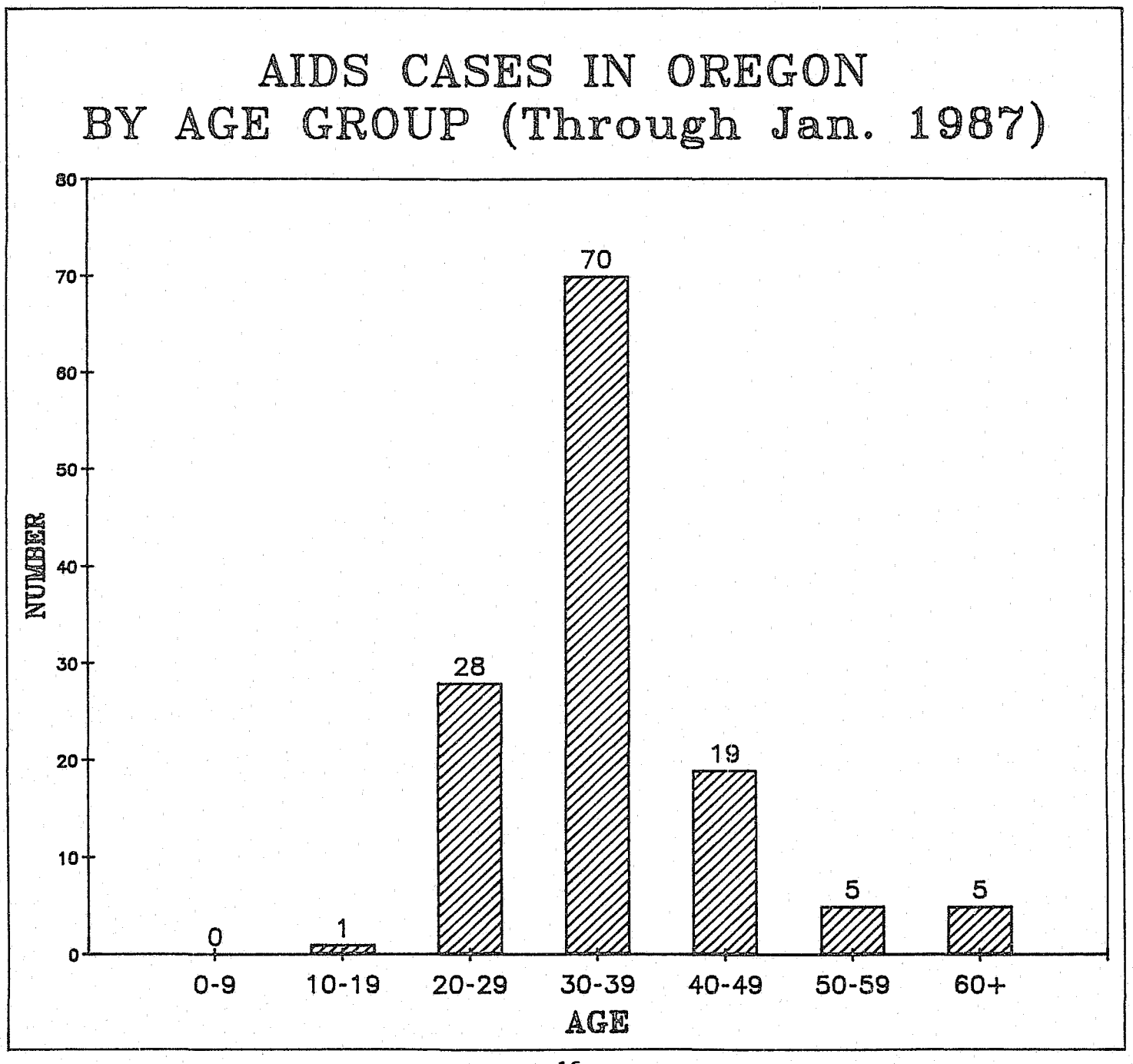
Current Status--Occurence of AIDS and Related Disorders

International AIDS has been diagnosed in residents of many countries on all generally populated continents. Incidence is highest in central Africa and Haiti, followed by the United States. The majority of cases reported in Africa appear linked to heterosexual contact.

National The Centers for Disease Control have estimated that in the United States at least 1.5 million persons are currently HIV infected. As of January 16, 1987, the CDC reported 29,536 cases of AIDS in the United States. Of these, 16,812, or 56 percent, are known to have died. The total case count is now doubling about every 13 months. The chart below shows the number of new AIDS cases reported each six month period from 1981 through December 1986.

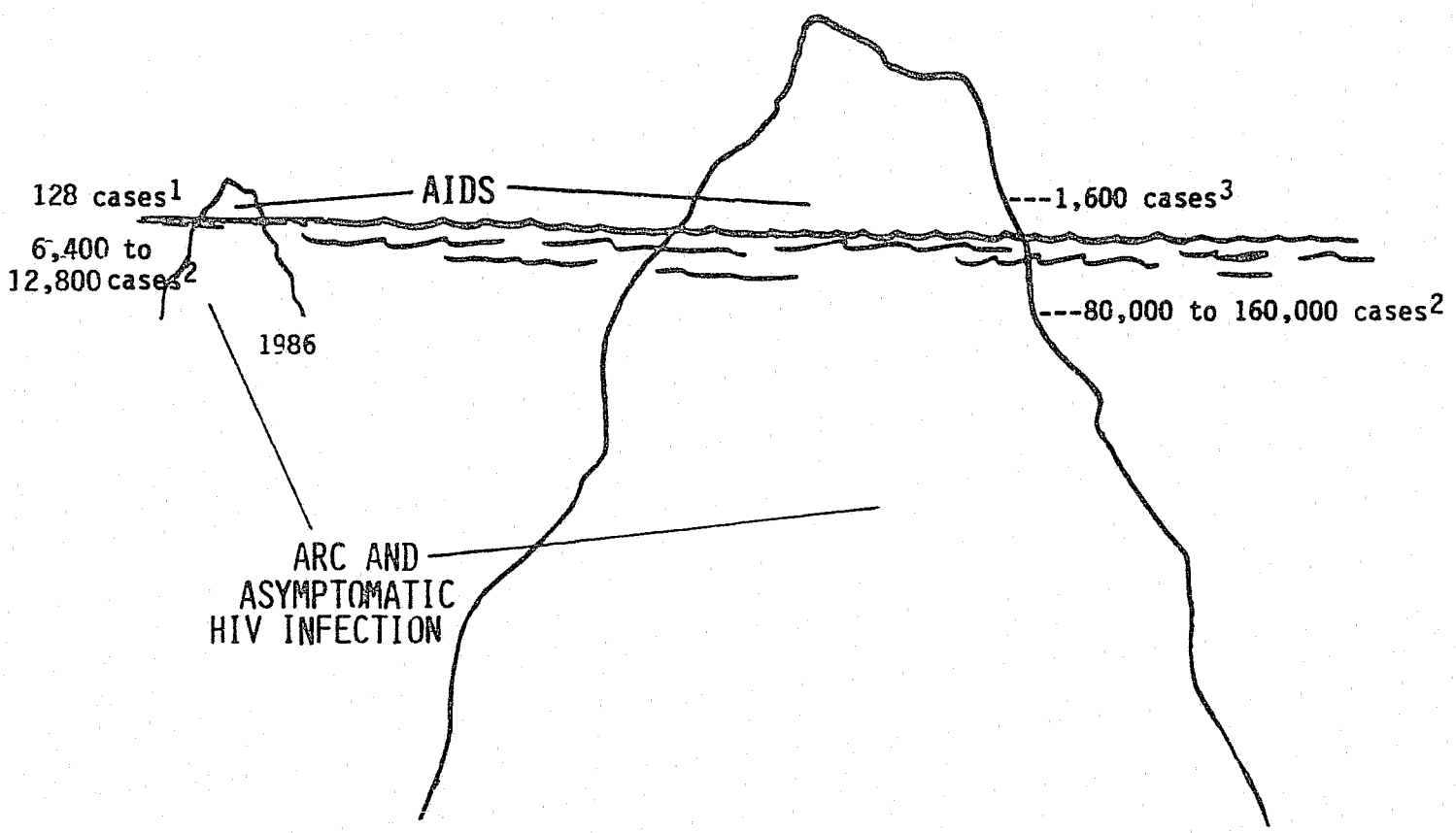


Oregon The Health Division has estimated that approximately 12,800 persons in Oregon are currently HIV infected. As of January 20, 1987, 128 cases of AIDS have been diagnosed and reported in Oregon. 125 males and 3 females have contracted the disease. Of Oregon's 36 counties, AIDS cases have been reported in the following: Clackamas-6, Coos-3, Douglas-1, Jackson-2, Jefferson-1, Josephine-3, Lane-9, Lincoln-1, Linn-2, Malheur-1, Marion-3, Multnomah-84, Polk-1, Tillamook-2, Wasco-1, and Washington-8. The graph below reflects the number by age, as reported to the Health Division through January 20, 1987. Age information reflects the age of the person at the time of diagnosis.



In addition to the cases diagnosed in Oregon, the Health Division is aware of 20 other persons residing in the state who have AIDS but were diagnosed elsewhere. As of January 20, 1987 the Health Division has recorded 81 deaths, approximately 63 percent of the reported cases. The number of reported cases in Oregon is now doubling approximately every 9 months, somewhat faster than the national average. This phenomenon is typical of moderate-incidence states, most of which are just now starting to experience the faster growth in cases as seen in the major urban areas a few years ago. The iceberg charts below demonstrate the estimated relative numbers of HIV infection, ARC and AIDS cases in Oregon for 1986 and 1989, as well as how the magnitude of the epidemic is expected to grow.

SPECTRUM OF CONSEQUENCES FROM HIV INFECTION
"ICEBERG PHENOMENON"
AS APPLIED TO OREGON



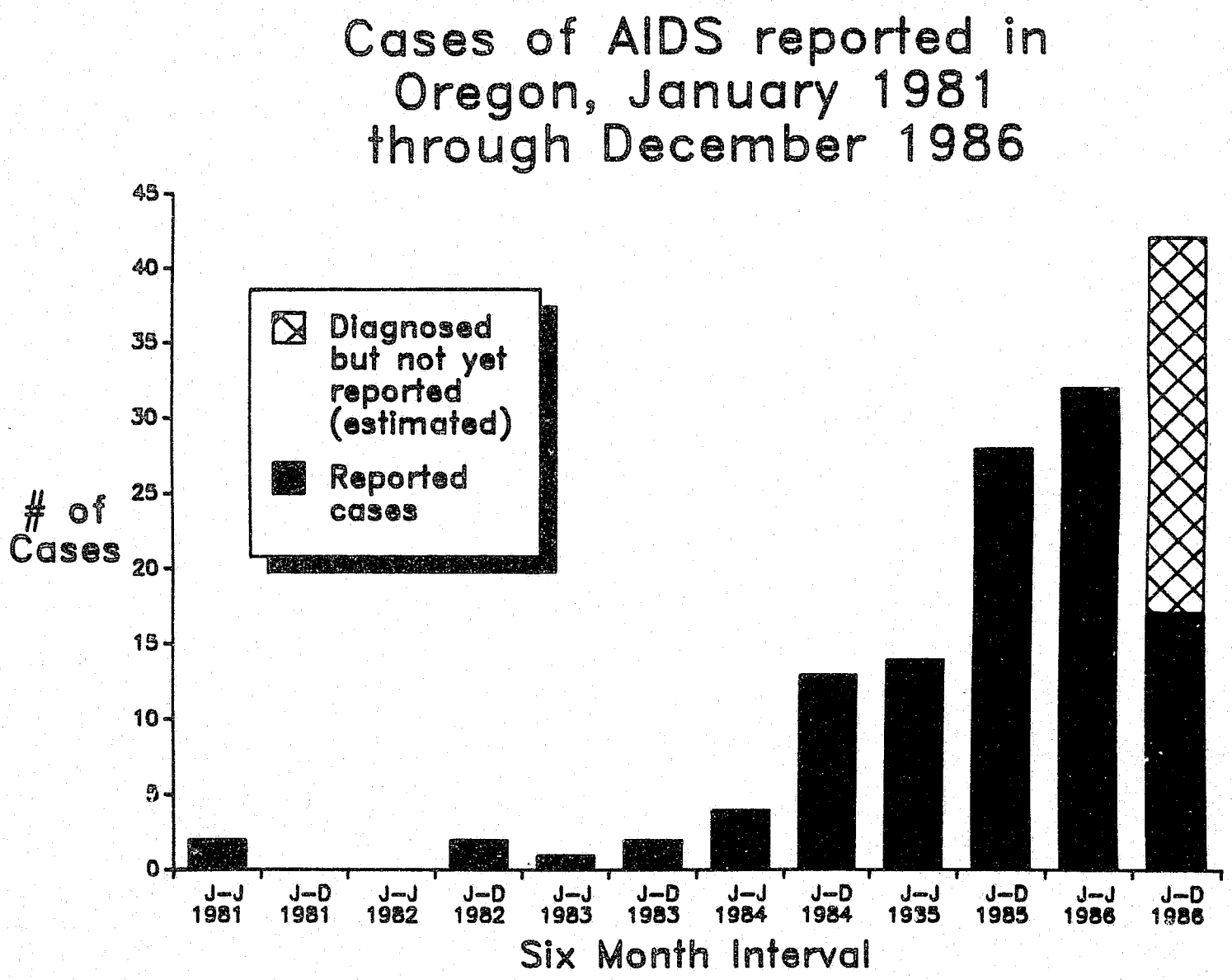
1989

1 Actual number of reported cases

2 Based on national estimates of 50 to 100 infected persons per diagnosed AIDS case

3 AIDS cases projected at current rate of doubling every 9 months

The chart below shows the number of new AIDS cases reported each six months in Oregon from 1981 through December, 1986.



Future Status: Projections

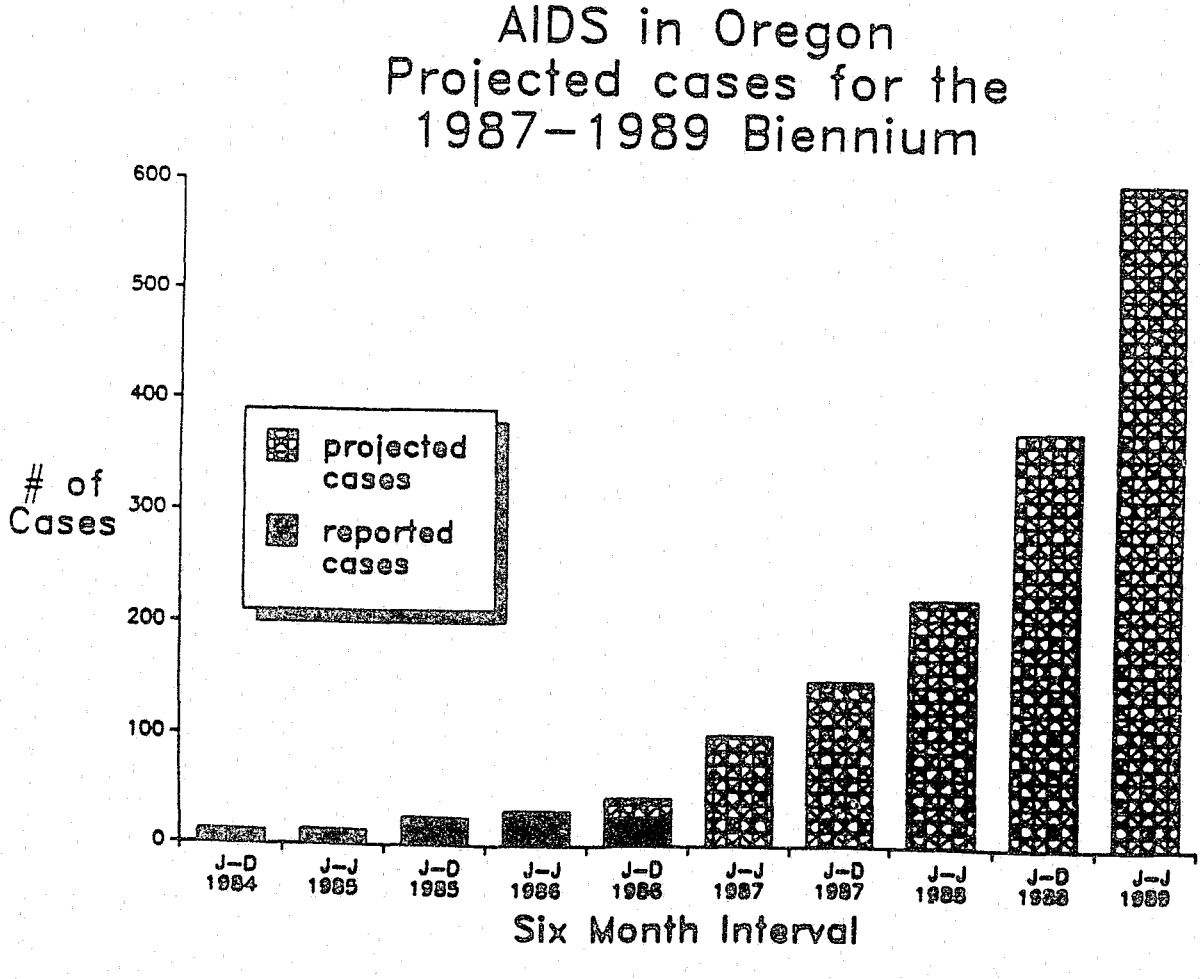
International Experts expect the number of AIDS cases to continue increasing in a near-exponential fashion for at least the next few years. With an uncertain incubation period and with relatively free passage across international borders by infected people, it is unlikely that any geographic area is now free of the virus.

National The U.S. Public Health Service (USPHS) forecasts that more than 270,000 cases of AIDS will have been diagnosed by 1991 and more than 179,000 of these patients will have died. The USPHS projects 54,000 deaths in 1991.

At present, the ratio of male to female AIDS cases in the U.S. is 15:1, with most of these cases occurring in men who engage in male to male sexual contact. In the next few years, as the virus spreads into the sexually active heterosexual male and female populations, that ratio will decrease, and its composition will change.

Oregon For the next few years, the doubling rate for Oregon AIDS cases will probably remain between nine months and 13 months, with the best estimate being nine months. If the rate of doubling stays at nine months and the death rate stays at 63 per 100, a total of 600 cases of AIDS will have been reported in Oregon by July 1988, with 222 still living, and a total of 1600 cases by July 1, 1989 with 592 still living.

The chart below demonstrates the number of new AIDS cases by six month intervals through the 1987-1989 biennium.



SCOPE OF THE RESPONSE

International Until recently there has been limited coordination at the international level. The World Health Organization now recognizes AIDS as a global problem, but has taken few steps to address the issue beyond co-sponsoring a series of international symposia on AIDS.

National The response to AIDS by gay organizations, government, civil rights and health agencies has been largely directed along three avenues: education/prevention, legal change, and research.

Education/Prevention - The focus of the education effort has been to notify persons at risk of the means by which they may reduce or eliminate their risk of contracting the virus. There has also been an effort to educate the general population about how the disease is and is not transmitted. Since early in the epidemic, gay organizations have provided risk reduction education, and urged government agencies to provide funding for widespread education and research. The USPHS, through its Centers for Disease Control in Atlanta, has funded a substantial proportion of the education effort. Individual state and local governments have also committed local resources to this program, generally in proportion to the number of AIDS cases reported in that state.

Legal - On the federal level, the U.S. Department of Health and Human Services, Office for Civil Rights, has issued a policy statement regarding AIDS and related conditions. According to the policy, Section 504 of the Rehabilitation Act of 1973 prohibits discrimination against persons based on the disabling effects of AIDS and related conditions. For detailed information, see Appendix, page 142. Many states and localities have enacted laws specifically aimed at the AIDS epidemic. These laws have related to areas similar to those addressed in this report. Few of the proposed new laws which restrict homosexual activities *per se* have been passed. From the beginning of the epidemic, gay and civil rights organizations have advocated for the rights of persons with AIDS and ARC and for persons considered at risk of infection.

Research - Research funds have been expended to study the nature of the diseases, develop diagnostic tools to identify infected persons and develop drugs and vaccines. The Department of Health and Human Services, U.S. Public Health Service provides a large part of the funding for this effort. Substantial amounts of private funding are also devoted to AIDS and HIV-related research.

Oregon

State Agencies In general, state agencies have responded to the AIDS epidemic by: providing educational programs, establishing rights protection policies, administering medical and supportive services and managing federal grants which fund a variety of public health services, including testing and lab analysis. State agencies actively addressing HIV/AIDS are:

Bureau of Labor and Industries

- Establishing a policy that persons with AIDS ARC and HIV seropositive test results are handicapped for purposes of protecting their civil rights against discrimination in employment. See Appendix, page 84.
- Currently drafting rules that extend handicap protection to the areas of housing and public accommodation. See Appendix, page 86.

Department of Commerce

- Educating staff regarding HIV infection, ARC and AIDS.

Department of Education

- Assisting Health Division to develop and update HIV/AIDS guidelines and education curriculum for use in public school system.

Department of Human Resources (DHR)-Adult and Family Services Division

- Providing funds and staff support for medical services including hospitalization, through Medicaid or GA (General Assistance) available to ARC or AIDS patients who meet eligibility criteria.
- Educating staff regarding HIV infection, ARC and AIDS.

DHR-Children's Services Division

- Educating staff and institutional residents regarding HIV infection, ARC and AIDS.

DHR-Director's Office

- Through DHR AIDS Task Force, developing curriculum for DHR agency AIDS training and providing practical guidance to agencies facing AIDS issues.

DHR-Alcohol and Drug Program

- Disseminating HIV, ARC and AIDS information to staff and clients of alcohol and drug abuse programs.
- Collaborating with the National Institute on Drug Abuse and National Institute on Alcohol Abuse and Alcoholism concerning information and treatment of program participants.
- Contracting for consultation, technical assistance and laboratory tests for drug or alcohol clients and providing staff support.

DHR-Corrections Division

- Educating staff and prisoners regarding HIV infection, ARC and AIDS.
- Working with national corrections to develop policies for institutions, addressing legal and medical issues.

DHR-Health Division

- Administering AIDS grants awarded by the U.S. Department of Health and Human Services/Public Health Service. Contract projects include: Community Health Education and Risk Reduction ($148,826), Counseling and Testing Sites ($123,551), and AIDS Surveillance ($93,963). Annual grants total $366,340 in federal funds.
- Monitoring the incidence and studying the epidemiology of AIDS in Oregon.
- Providing free lab resources for HIV antibody testing.
- Administering the statewide AIDS Education Program.
- Preparing certified AIDS trainers who are sources of health information and provide educational programs at local level.
- Educating persons throughout the state via informational programs. In 1986, staff presented over 300 programs for approximately 7,000 people.
- Preparing updates and disseminating policy guidance on AIDS for schools, health care facilities and workplaces.
- Providing curriculum guides for teachers in Oregon schools.
- Educating the public through printed materials, telephone consultations and media appearances.
- Administering trial program of anonymous HIV antibody testing in 33 Oregon counties.

DHR-Mental Health Division

- Educating staff and patients regarding HIV infection, ARC and AIDS.
- Administering payments for psychological care of AIDS patients who meet eligibility criteria.

DHR-Senior Services Division

- Educating staff regarding HIV/AIDS.
- Administering programs to provide skilled nursing care, home care services, alternative community care services, and special equipment for AIDS and ARC patients who meet eligibility criteria.

Governor's Office-Citizen's Representative

- Responding to informational inquiries regarding availability of state services.
- Receiving complaints regarding state agency actions.
- Coordinating with state agency personnel to provide information and resolve complaints.

Local Government Response

County health departments throughout the state either directly provide HIV testing and counseling or refer individuals to nearby county health departments for HIV testing and counseling. All but three (Benton, Lane and Linn) offer anonymous testing as an option. AIDS trained public health nurses and specially educated AIDS trainers offer a spectrum of services to individuals and groups. The services range from targeted educational programs to policy development assistance. Groups such as school students, prisoners at correctional facilities, county department heads, school nurses, community organizations, high risk groups, and staffs at various state and federal agencies have received AIDS information through the efforts of county health departments.

Each county health department has a designated staff member who is responsible for HIV counseling and testing. See Appendix, page 87 for a listing.

Community Organizations' Response

Community based organizations have contributed substantially to the overall response in Oregon. Those currently active and exclusively devoted to AIDS matters are:

Cascade AIDS Project (Primarily serving the Portland metropolitan area)
- Educating and training groups and individuals regarding AIDS and, specifically, risk reduction behavior.
- Providing emotional and practical support services for diagnosed individuals, their families, and loved ones.
- Advocating for people with AIDS and ARC with local governments and private agencies to assure needed services.

Coalition for AIDS Education (Primarily serving the Portland metropolitan area)
- Designing and presenting special education programs for groups expressing an interest.

Mid Oregon AIDS/Health/Educational Support Services, Inc. (Primarily serving central and coastal Oregon)
- Offering education and training for individuals in other community organizations so as to create a network of resource people in a variety of organizations within rural communities.
- Providing community hotline services.
- Reviewing and making case recommendations for community volunteer workers.
- Initiating and /or participating in public meetings to provide health and risk reduction information.

Mid-Valley Action Committee (Serving Lane County)
- Advocating for persons who have AIDS, ARC or are HIV seropositive.
- Providing education services, including community forums.
- Making referrals to appropriate medical practitioners.
- Coordinating with other community organizations.
- Providing support groups and limited other support services for persons who are HIV positive.

Oregon AIDS Task Force (Statewide)
- Assisting in formulation of health care policy regarding HIV infection, ARC and AIDS.
- Working with county health departments and community groups to formulate policies.
- Providing educational programs for groups throughout the state.

Shanti in Oregon, Inc. (Serving Lane County)
- Providing emotional support programs for persons affected, either directly or indirectly, with AIDS or ARC, including counseling in pain management, wellness programs and death and dying.
- Offering support groups for persons with AIDS or ARC, significant others and caregivers.

Willamette AIDS Resource Council (Serving Lane County)

- Providing education regarding safe sex practices.
- Offering special outreach to drug abusers.
- Working to establish network with attorneys.
- Making targeted information available to medical and health care communities.

Other organizations provide at least intermittent activities and programs devoted to HIV infection, ARC and AIDS. Many of these organizations are composed exclusively of volunteers, and their importance in the overall state response cannot be overemphasized. See Appendix, page 92 for the listing of resource agencies in Oregon.

RECOMMENDATIONS

Basic Principles

Several basic principles guided the HIV/AIDS Policy Committee as it addressed the wide range of issues surfaced by HIV, ARC and AIDS. These principles, identified below, provided the context for discussion and resolution. This listing of principles and attendant subparts is not a priority ranking. They are all interrelated and critical to an effective public policy.

- Stopping the spread of HIV infection, ARC and AIDS in Oregon is critical to the overall medical, economic and social health of this state. It is the responsibility of government, through public health agencies, to insure to the greatest extent possible, the protection of the general citizenry.

  - -HIV infection, whether manifested as AIDS, ARC or other patterns of infection, is and will remain an extremely serious public health problem in the foreseeable future. Thus, preventing further spread is a high priority.

  - -It is in the best health, economic and social interests of all Oregonians to promptly and responsibly address the issues raised by the presence of HIV infection, ARC and AIDS in this state.

  - -Currently, education is the most effective tool available to combat the spread of HIV infection and improve use of treatment and support services.

  - -New funds should be allocated to carry out these recommendations.

  - -Because of the extreme gravity of the AIDS epidemic, it is necessary to educate people in safe conduct of activities that are criminal, i.e., illicit IV drug use.

- An effective HIV/AIDS policy must acknowledge and address the tensions arising between general public protection and individual freedom concerns.

  - -Both the public health rights of uninfected persons and the civil rights of persons with AIDS or HIV infection should be recognized and protected.

  - -Education and other non-coercive measures should be employed whenever there is reason to believe they will be effective. Coercive measures, such as quarantine, should be reserved for situations where non-coercive measures have failed or can be clearly expected to fail.

  - -The protections of the handicap laws should be fully available to persons with AIDS, ARC or HIV infection.

  - -Policies should be based on public health considerations, not fear.

- HIV/AIDS policy must recognize and address the anxiety created in high risk populations by fear of discrimination and stigmatization resulting from association with HIV infection, ARC and AIDS.

  - -The recommendation process must reflect and respect the legitimate concerns of all those affected by the decisions.

  - -Maximum use should be made of community groups having specialized communication skills and opportunities relative to specific target populations.

  - -AIDS policy and law should attempt to eliminate the stigma of AIDS and discrimination against infected individuals.

  - -Reporting and government services should be conducted so as to respect the confidentiality, dignity and privacy of clients.

  - -The AIDS epidemic requires rethinking some public health laws.

- Effective coordination of adequate educational, medical and support services is essential in responding to existing HIV infection, ARC and AIDS, as well as combating the spread of these conditions.

  - -AIDS is a disease of such importance that public resources must be expended to assure preventive actions and access to quality medical services.

  - -AIDS or ARC patients face many of the same financing and access issues as other persons with catastrophic diseases.

  - -The scope of health education available to AIDS and ARC patients must not be limited to safer sex practices.

  - -Where services exist, it is critical to assure continuing access and equal treatment in delivery.

  - -Services should be coordinated so that funds are not unnecessarily expended as a result of duplication.

  - -Consistent with the principles of sound medical practice and efficient fund use, treatment of AIDS should be provided in the least restrictive and least costly setting necessary for adequate care.

  - -Wherever possible, without compromising the integrity of the insurance system, medical expenses should be covered by private health insurance.

  - -No one who is medically ill should be without adequate care.

PUBLIC HEALTH MEASURES

Communicable Disease Statutes

Issue

Statutory provisions determine how to respond to a particular disease or medical condition for the purpose of community protection. The provisions mandate the level of responsibility a local health department has in regard to providing services relative to a particular disease or medical condition, and the responsibilities for reporting conditions to official agencies. At issue is the appropriateness of ORS 433 (Communicable Diseases) and ORS 434 (Venereal Diseases) in relation to HIV, ARC and AIDS.

Current Status

ORS 433 requires reporting of all communicable disease and provides minimum confidentiality protections. ORS 434 specifically identifies venereal diseases to be reported and provides a high level of confidentiality protection. It also requires local health departments to provide individuals free treatment for venereal diseases.

ORS 434 also requires physicians to instruct persons having venereal diseases in precautionary measures, restricts advertising and distributing of venereal disease cures, and requires local health authorities to ascertain cases and sources. With these exceptions, the principal provisions of ORS 434 (reporting, examination, quarantine and isolation) duplicate provisions now found in ORS 433.

Under Oregon Administrative Rule, because AIDS is a communicable disease under ORS 433, it is reportable by name. It is unclear if AIDS is a venereal disease within the current definition in ORS 434. No official action has been taken to classify HIV and ARC under ORS 433 or 434.

Recommendations

1. The Legislature should repeal the Venereal Disease statute, ORS 434.

2. The Legislature should adopt the proposed bill submitted with this report. See Appendix, page 104. It amends the Communicable Disease statute, ORS 433 to:

   a. Provide in reporting all communicable diseases, a high level of confidentiality protection

   b. Require the Health Division to identify, by Administrative Rule, the communicable conditions to be reported

   c. Eliminate the requirement of local health department services to provide free treatment for ARC or AIDS

e. Reflect that public health officials should exercise quarantine authority only as a last resort, on a case-by-case basis, in rare instances where a person infected with HIV, ARC or AIDS knowingly and willfully exposes another to the infection in a manner or under conditions not likely to provide notice of potential exposure. See Appendix, page 110 for quarantine provisions within the proposed amendment of ORS 433.

Rationale

There is no public health justification for handling venereal diseases differently from other communicable conditions. In addition, general purpose consumer protection statutes have eliminated the need for any consumer protection statutes specifically restricted to venereal diseases. County health department resources should be used for free treatment only when such treatment is a cost effective means to reduce transmission of the disease, as it is for tuberculosis and gonorrhea.

Budget Appropriation Required - $0

PUBLIC HEALTH MEASURES

REPORTING

Issues Common to Majority and Minority Reports

It is well established in public health law and policy that health care providers should be required to report cases of certain communicable diseases to official public health agencies. Diseases have generally been selected for mandatory reporting if they meet three criteria:

- The disease is significant in its potential to cause serious illness, disability, or death
- The disease may spread from the identified case to others, or from the identified case's source to others and
- There is some action the public health agency can take, in response to the report of a case, to prevent spread to others, and that action could not be taken without awareness of the case.

On occasion, communicable diseases which do not fully meet these three criteria have been made reportable. This has usually been to support special epidemiologic studies or to provide estimates of the size and nature of the disease problem in the community for program planning and policy making.

All categories of HIV infection (AIDS, ARC, and asymptomatic HIV infection) meet the three basic criteria for mandatory reporting. The infection is significant in its potential to cause serious illness, disability or death. It may spread from one person to others. The public health agency can provide targeted counseling to infected persons and their contacts to reduce the spread of infection to others. Mandatory reporting of all categories of HIV infection could additionally be supported for the purposes of special studies, program planning, and policy making.

Current Status

Oregon Administrative Rules and the Communicable Disease statute require certain health care practitioners to report AIDS by name. ARC and HIV positive test results are not now reportable in any fashion.

Recommendations Common to the Majority and Minority Report

The HIV/AIDS Policy Committee, as a whole, notes that the recommendations presented by both the majority and minority reflect what each believes to be the optimal response in stopping a public health epidemic. Neither the majority or minority has hard statistical data available to support their respective recommendations.

1. Health care practitioners should continue to report AIDS cases by name.

2. The Health Division should promulgate an Administrative Rule to require reporting cases of ARC and asymptomatic HIV infection. The majority and minority differ as to whether these cases should be reported by name.

3. The Health Division should initiate and distribute a form for reporting HIV, ARC and AIDS which requires the reporting health care practitioner to certify that the patient seeking HIV testing has been provided with an opportunity for counseling and/or educational materials.

MAJORITY REPORT

Issue

AIDS, ARC, and HIV infection are currently different from other reportable communicable diseases in two key ways. The first has to do with the potential social stigmatization of those known to be infected.

Other diseases have been associated with stigma. Tuberculosis, for example, has long been associated with poverty and particularly alcoholic derelicts. Syphilis has been associated with sexual promiscuity. The stigma generally associated with these other diseases, however, has much less potential for inciting bigotry, hatred, and significant discrimination than does HIV infection, ARC or AIDS.

The association of male homosexuality and drug use with HIV infection does, unfortunately, create the potential for significant discrimination against persons identified to be infected. This potential dictates that the present mandate to report AIDS, as well as any extension of this requirement to include ARC and HIV infection must be balanced with commensurate safeguards of confidentiality and protection against discrimination. The need for this balance is emphasized by the extreme concern and undercurrent of panic about AIDS seen in some segments of the population.

It is certain that fears about discrimination will keep many well, high risk persons from seeking the antibody test. It is possible that such fears may keep some persons with ARC from seeking diagnosis and care. Until these fears are mitigated by specific statutory protection, it is certain that mandatory reporting, by name, of positive HIV-antibody tests and ARC will discourge many from seeking the test, and thus lead to a serious underestimate of the number actually infected. It is equally certain that even statutory protection will not sufficiently allay the long-standing fears of discrimination. Therefore, a creative approach is needed in order to achieve the goals of reporting.

The second difference from other diseases is the currently limited potential for preventive action by the public health agency. When a case of syphilis is reported, the patient and his or her contacts can be given penicillin to stop the infection. With HIV infection, no such definitive action is possible. Only education regarding sexual activities and needle sharing can be given, and that is effective only to the extent that the individual follows the advice.

The purposes that could be achieved by mandatory reporting of all categories of HIV infection include:

1. Assuring that persons with AIDS, ARC, or HIV positive tests receive counseling about how they can avoid spreading the infection to others

2. Assuring that infected persons are encouraged to notify sexual contacts and needle sharing contacts so that they, too, can seek counseling regarding their possible exposure

3. Defining the numbers of persons with AIDS, ARC, or HIV positive antibody test in the population for purposes of program planning, policy making, and funding

4. Supporting special epidemiologic studies

5. Assuring that affected persons are notified of effective treatment programs when they become available.

Recommendations

1. The Health Division should require, by Administrative Rule, reporting categories of HIV infection other than AIDS diagnosis (i.e., ARC or HIV seropositivity) through the anonymous system detailed below.

2. All persons seeking testing for HIV infection should be counseled regarding risk reduction and notification of their sexual and needle-sharing partners. At a minimum, they should be given educational materials provided by the Health Division which contain information identified above, as well as information on local counseling and support services.

3. For patients who seek HIV antibody testing, health care practitioners in the private sector should complete and sign a laboratory report form provided by the Health Division which:

   a. Specifies that the patient has been given the Health Division educational materials and has had an opportunity to ask questions about the tests, and

   b. Contains spaces for the following information:

      1. the patient's age, sex and county of residence
      2. whether the patient has had a previous positive HIV antibody test
      3. whether the patient has donated blood or plasma since 1977
      4. the date
      5. the test results (to be completed by the laboratory).

4. Local health departments should follow the procedure described in Recommendation 2 for persons seeking confidential or anonymous HIV testing. Counseling will be done as part of pre-test screening, and documented in the patient's record by their counselor. Individuals with positive results should be reported anonymously and automatically by the Public Health Laboratory to the Epidemiology Section by means of a copy of the laboratory request form.

5. The Health Division should develop and distribute educational materials to health care practitioners for use by their patients.

6. The Health Division should require licensed clinical laboratories to accept serum specimens for HIV testing only if accompanied by a completed form as described above.

7. The Health Division should require licensed clinical laboratories in Oregon to submit the completed copy of the prescribed form to the local health department or Health Division for all individuals tested for HIV infection. It should similarly require health care practitioners to submit the completed form directly for patients whose serum was tested in laboratories outside Oregon.

Rationale

This approach will accomplish the goals of reporting. By not requiring HIV infection reporting by name, it will avoid the problem of decreasing numbers of people benefiting from counseling and testing. To the extent that anonymous testing increases the willingness of persons to interact with either local health departments or private health care practitioners there is an increasing opportunity to provide counseling and education to these people. To the extent that the counseling and education is effective, the spread of HIV infection is reduced. This reduction results in a cost savings, in terms of both human and financial resources.

Budget Appropriation Required

See Preventive Services Budget, page 38, incorporating reporting and contact notification costs.

MINORITY REPORT

Issue

The frightening extent of the AIDS epidemic has been documented in other portions of this report and is the basis for this committee's existence. One of the major goals of this committee has been to propose means by which the spread of this disease may be limited. It is our stand that only by reporting individual's by name who are known to be infected by the AIDS virus can we limit the spread of this virus.

From a medical and scientific viewpoint the spread of AIDS is not determined by who is actually ill (i.e. AIDS or ARC) but by who is infected with the virus with or without illness. Indeed, a strong case can be made that it is the infected asymptomatic individual who is most likely to spread the infection and the blood or sexual contact of this person who is most likely to be unknowingly exposed and infected by the virus. Thus, the ability to definitively contact the known carriers of this virus is paramount in diminishing the spread of the infection. Without the name of the index case, one must rely solely upon the good will of the index case for effective notification of contacts. Although this good will is usually present this is not always the case. In some risk groups it is highly likely that the infected individual will not notify possible contacts (i.e. IV drug abusers and prostitutes).

Furthermore, it is well recognized that individual health care providers vary considerably in their knowledge of AIDS and HIV infection and in their ability to counsel effectively. Only by insuring that HIV-infected individuals can be located can the effectiveness of the counseling be evaluated and the results of effective counseling upon behavior patterns determined.

Finally, the majority report states that members of risk groups will not allow themselves to be tested if they are reported by name, and therefore they will not receive counseling. We maintain that the result of a test is irrelevant vis-a-vis behavior pattern alteration. All risk group members should alter behavior regardless of the result of an HIV test; counseling can be offered at separate centers without the HIV antibody test and with no need for identification. The majority report even states that "education is available to persons at high risk..." We agree, and feel that the reporting and education issues should not be confused.

We agree that the potential for infringement of individual liberty is present if reporting by name is adopted. We believe strongly that although no breach of confidentiality has occurred to date in the Oregon State Health Division or Local Health Departments, explicit, strict, and severe penalties should be present and enforced if such a break should occur. Job, housing, health care, and insurance protections should also be adopted and enforced.

It is indisputable that HIV infection and the related diseases constitute a major public health threat. Every member of the committee agrees that HIV infection meets the three basic criteria required for mandatory reporting of disease to the appropriate health department. We believe that the general public's welfare is best served by using the same criteria for reporting any stage of HIV infection by name as any other disease. Only reporting by name allows individuals to be contacted if and when therapy becomes available as proposed in the majority report.

Recommendations

1. All categories of HIV infection should be reported by name to the appropriate Health Departments. This should be accomplished by Administrative Rule if possible.

2. The form suggested in the majority report should be used as described except for the addition of the infected individual's name.

3. Educational materials and counseling should be available as described in the majority report independent of the person's decision to take or not take the HIV Antibody test.

Rationale

This approach will allow the goals of reporting to be met. Only this approach will allow accurate auditing of the system to assure, not just hope, that the goals of reporting are met.

Budget Appropriation Required

Printing and mailing forms - $7,500
Health Care
Practitioner Education - $5,000
Clerical Support .1 FTE - $3,600

Submitted by:

Marge Erwin RN, BSN
Marge Erwin, R.N., B.S.N.

George G. Goldthwaite

Sherral Landsiedel
Sherral Landsiedel, R.N., B.S.N.

Robert Lawrence
Robert Lawrence, M.D.

Thomas Ward
Thomas Ward, M.D.

PUBLIC HEALTH MEASURES

Contact Notification

Issue

No issue attendant to the HIV/AIDS epidemic requires more sensitivity and reflection than that of contact notification. The issue of contact notification arises when a person becomes aware that he or she is HIV infected. Because HIV infection is communicable, those persons who have shared needles or engaged in unsafe sex practices with the infected individual or have received blood transfusions from that individual may also be HIV infected. For the purposes of this Recommendation, those persons are designated "contacts."

An effective policy regarding notification of potentially HIV infected contacts requires balancing legitimate concerns. On one hand, there is the critical public health concern for stopping the spread of HIV infection. The risk of infecting others is no less great if a person unknowingly transmits the HIV virus. In addition, there is consideration for that contact's right to make informed choices about his or her health. With a knowledge of potential HIV infection, a person may make a different choice concerning his or her own HIV antibody testing. That knowledge may also increase motivation to receive intensified education regarding safer health practices to prevent infection.

On the other hand, a notification policy must respect a contact's right to privacy. When a person chooses to take the HIV antibody test, that choice includes the decision to interact with a health care provider. To that extent, the person chooses to surrender a degree of privacy. However, consent to medical diagnosis and treatment does not generally imply either the patient's consent to contact notification or the contact's consent to notification. Those contacts have not sacrificed their right to privacy, a right to choose whether or not to be known as being at risk of HIV infection. Identification with a high risk group, i.e. males who engage in male to male sexual acts, and IV drug users, often results in a fear of discrimination, stigmatization or criminal prosecution. To the extent that the HIV infected party choosing to be tested is a member of a high risk group, a person identified as a contact of that party can be associated with the risk group, and be possibly subject to the same discrimination, stigmatization and criminal prosecution if confidentiality is breached. Notification puts the contact in the position of taking a risk of confidentiality breach without the opportunity to choose such a risk.

On the same side of the balancing as a contact's right to privacy is the resource issue. There is not an unlimited supply of funds available to address the HIV/AIDS epidemic in Oregon. The total incidence of contacts is not known. The cost of locating all contacts could well jeopardize funding other measures. Factors include: the five year presence of AIDS and the minimum eight year presence of HIV infection in the U.S., the relatively high frequency of non-monagamous sexual activities and the potentially high number of needle/syringe sharing opportunities.

The balancing of these issues to reach a policy recommendation must be done in a context of certain underlying premises. There are four warranting specific discussion.

First, AIDS is a fatal disease and the number of cases continues to increase dramatically. Unless it is checked, the AIDS epidemic will become one of our most serious public health problems in terms of deaths and the drain on health care resources.

Second, there are undoubtedly a large number of persons who do not perceive themselves at risk of HIV exposure yet unknowingly have been exposed. They include: children of infected mothers, female sex partners of closeted bisexual males, victims of sexual abuse or rape by HIV infected persons, recipients of blood from HIV infected persons, males who believe themselves to be in monogamous relationships with other males, sex partners of closeted IV drug users, and men who engage in male to male sex acts or IV drug users, who know they are members of high risk groups, but have not accepted the fact that the risk applies to them personally. This denial, "It can't happen to me," is widely recognized with respect to many kinds of risks.

Third, the general fears of discrimination that many gay people feel are deep seated and well founded. Similarly, the IV drug user's fear of criminal punishment is real. Thus, a policy of mandatory contact notification of all contacts would be self defeating in that it would discourage potentially HIV infected persons from seeking appropriate testing, counseling or medical care. The result of such a policy could actually increase transmission of infection. Administrative and statutory assurances of confidentiality will not eliminate these long standing fears, at least in the span of a few years.

Fourth, it is not the responsibility of a private health care practitioner to directly notify persons outside his or her practice that they are at risk of HIV infection as a result of contact with his or her patient. That is traditionally the role of the public health agency when the infected individual chooses not to make the notification.

The Recommendations regarding a contact notification procedure are intended to achieve the maximum possible disease prevention benefit in the context of these four considerations.

Current Status

There is no statewide policy specifically addressing contact notification relative to HIV seropositive test results with the exception of blood transfusions.

Recommendations

1. Both public health department personnel and private health care practitioners, as part of pre- and post-HIV test counseling regarding safe health practices, should urge their clients to personally notify all contacts.

2. During pre-HIV test counseling, health care practitioners discussing contact notification, should stress to the individual that contacts be strongly encouraged to interact with the local health department. It should be made clear that the reason for such an interaction is because the contacts have engaged in an unsafe practice and there is a need for education. If the individual is reluctant to personally confront contacts, the local health department and the private health care practitioner should offer to provide the individual with information packets regarding HIV infection information which the individual may send to contacts.

3. The Health Division AIDS Program staff should develop and distribute to local health departments information packets for contacts, to be used by the departments in the counseling process, or for distribution to private health care practitioners.

4. If an HIV infected person expresses a reluctance to notify contacts, the private health care practitioner should inform the person that local health department staff, trained in contact notification procedures, is available to assist that person in notifying certain classes of contacts. If the HIV infected person chooses to use local health department staff to accomplish contact notification, staff should notify those contacts who have no reason to expect they are at risk of exposure. Such persons are: minors, female sexual partners of HIV infected promiscuous heterosexuals or closeted bisexual males, hemophiliacs, victims of sex abuse or rape by the HIV infected person, males who believe themselves to be in a monogamous relationship with an HIV infected person, sex partners of closeted IV drug users, or others identified as having little reason to expect they are at risk of exposure.

5. If the health care practitioner responsible for an HIV infected person's care believes such person has not assured that sexual or blood contacts contacts have been notified of their personal risk of HIV infection, and if the practitioner knows the identity of such contacts, the practitioner must notify the local health department of the situation and provide it with the names of the contacts. The local health department must notify such contacts as would not otherwise be considered at high risk of exposure to HIV infection, as identified in Recommendation 4. The health care practitioner should advise the infected person of the notification.

6. Information identifying such contacts of the index-infected person must not be part of the permanent medical record of the health care practitioner, and should be forwarded to the local health department.

7. Local Health Department staff must comply with established confidentiality protections applicable to contact notification procedures.

8. The Health Division should adopt rules where appropriate, reflecting the procedures identified in these Recommendations.

Rationale

Personal notification of contacts by the HIV infected person best protects privacy and state resources. These individuals should be counseled to notify all their contacts. Infected persons (whether with HIV or other communicable diseases) are often reluctant to confront those whom they have possibly infected. In the case of HIV infection, the incremental value of notifying contacts who should already know from general community education that they are at high risk is currently outweighed by the potential drain on available resources. These resources are better used to develop and deliver general education to all high risk group members. Thus, at this time, contact notification of only those who have little reason to suspect possible infection best balances all concerns.

Budget Appropriation Required

See Preventive Services budget, page 38, incorporating reporting and contact notifications costs

BUDGET

PREVENTIVE SERVICES DIRECTED TOWARD INDIVIDUALS

ITEM	MAJORITY REPORT		MINORITY REPORT	
	#SERVED	AMOUNT	#SERVED	ADDITIONAL AMOUNT
- Counseling in STD Centers		$387,875		0
- Statewide coordinating, training and evaluation by Health Division		91,233		0
- Individual counseling by local health department staff @ $34 ea.	10,000	$340,000	11,741	$ 61,370
- Laboratory costs for HIV antibody testing @ $10.30 each	15,000	$154,437	16,741	$ 17,932
- Health Department notification of contacts (interview doctor, interview reported infected person, locate contacts and refer them for counseling)	435	$ 30,004	2,176	$133,173
			ADDITIONAL	$212,475
	MAJORITY REPORT TOTAL	$1,003,549	MINORITY REPORT TOTAL	$1,003,549
				$1,216,024

These figures are based on the seven basic assumptions listed below. To the extent the assumptions are incorrect, these estimates of cost and benefit will also be incorrect.

1) The major justification for the majority approach to reporting is that reporting persons with HIV infection or ARC by name, and local health department notifications beyond those requested by the index case or required under Recommendation 5 could discourage persons from seeking counseling and testing.

2) The minority report is premised on the assumption that reporting of persons with ARC or HIV infection by name will not discourage individuals from seeking counseling and testing.

3) That demand for testing and counseling services increases in response to education and increased awareness.

4) 5,000 additional tests coming in from the private sector are expected.

5) That 20% or 435 of these "unaware" contacts will be identified and actively sought out by health departments under the plan outlined in Contact Notification Recommendations 2, 4 and 5, pages 36 and 37.

6) That 1,741 "unaware" contacts will be identified by local health department notifications beyond those requested by the indexed case. (See Recommendation 4, page 30.)

7) Given the assumptions outlined above, the contact notification used to justify the minority report would cost an additional $212,475 and an additional 1,741 "unaware" contacts would be notified.

See Appendix, pages 128-129 for data basis for the preceding assumptions.

PUBLIC HEALTH MEASURES

Quarantine

Issue

Quarantine is the enforced separation of an infected person from those who that person is likely to expose to infection. Its purpose is to prevent transmission of a disease from one person to another. In the past few decades, persons with the authority to quarantine in Oregon have rarely exercised it. When they have, it has been to control the behavior of persons infected with diseases such as tuberculosis, which are airborne spread. For such highly contagious diseases, casual exposure to an infected person puts others at risk, which is not the case with HIV infection.

Balancing against the availability of quarantine power is the recognition that quarantine is a significant infringement on constitutionally protected liberty rights. This balancing is within a context of other established legal measures available in responding to persons with HIV, ARC or AIDS that address the dangerous behavior. If such an individual is not mentally responsible for the behavior resulting in transmission, civil commitment procedures are appropriate. Criminal sanctions are available if a person with HIV, ARC or AIDS transmits the virus through an act of rape or to a child. The context also involves the concern that abuse of quarantine could prove counter-productive. There is a substantial possibility that actual or perceived abuse of the quarantine power would drive persons at risk away from educational or public health resources. This increases the possibility of transmission because of a lack of education.

At issue are the conditions under which a quarantine is the appropriate public health response.

Current Status

The Administrator of the Health Division or a county health officer has the statutory power to "isolate or quarantine people...or institute other preventative medical measures...to prevent the spread of communicable diseases of threat to the community." ORS 433.106. ORS 434, which this Committee has recommended repealing, has similar authority for venereal diseases. The statutes also authorize using quarantine as the sanction to enforce compulsory examination. Other coercive public health statutes (e.g. civil commitment under ORS 426) have been amended to comply with contemporary theories of due process and fair procedure. The current quarantine statute contains fewer due process protections than the civil commitment statute. The Health Division has submitted a draft bill, amending the current ORS 433. That bill is the basis for Recommendations in this Report. See Appendix, page 104.

Recommendation

1. The Legislature should adopt the amended Communicable Disease statute, ORS 433. The Committee submits the draft bill amending ORS 433 with the understanding that it reflects specific principles and procedures:

   - Public health officials should exercise quarantine authority only as a last resort

- Quarantine should apply on a case-by-case basis, in those rare instances, where a person infected with HIV, ARC or AIDS knowingly and willfully exposes another to the infection, in a manner or under conditions not likely to provide notice of potential exposure, after attempts to educate that person regarding disease transmission, and the person continues or intends to continue exposing others to infection.

- Quarantine may be imposed only if four conditions are met. First, the person is afflicted with a reportable disease or condition. Second, the person poses a substantial threat to public health. Third, the person is unable or unwilling to behave so as not to expose other persons to danger of infection. Fourth, quarantine is necessary and is the least restrictive alternative measure under the circumstances to protect or preserve the public health.

- The statute should require due process and fair procedure provisions for quarantine. Similar procedures should apply to mandatory examination and other public health orders. The particular procedures should include: Circuit court proceeding initiated by a public health official, sworn affidavit and petition, a five-day limit on detention without hearing, notice stating the allegations and the person's rights, a probable cause preliminary hearing, an investigative report, court-appointed medical examiners, legal counsel, appointed counsel if indigent, subpoena and cross examination of witnesses, proof by clear and convincing evidence, 60-day limit on court orders, discharge when the threat to public health has passed, and rehearing available after 60 days.

- Quarantine procedures should be modeled after civil commitment procedures under ORS 426.

2. Prior to Legislative hearings, the Health Division should conform the bill as necessary to the amendments to ORS 426 (the statute addressing civil commitment procedures) that the Interim Task Force on Mental Health has proposed and should make any other technical corrections needed.

3. The Health Division should issue Administrative Rules for the use of quarantine authority in controlling various medical conditions, including AIDS, ARC and HIV infection.

Rationale

Respect for individual liberty protections demands judicious use of quarantine powers. Absent an individual's disregard of the rights of others, there is no health policy justification for using quarantine. Such an action by public health officials is no less than a step of last resort. Its use must be limited to specifically egregious situations and must conform to modern due process procedures.

Budget Appropriation Required

Administrative procedure - May require state funding of attorneys, physician and testing fees for indigent persons subject to quarantine procedures. There may also be administrative hearing costs. No data available on which to base cost projections.

QUARANTINE

MINORITY REPORT

Recommendation

1. Because the HIV (AIDS) virus is not spread by casual contact, and because we believe established legal measures sufficiently address dangerous behavior, the use of quarantine is never appropriate as a public health measure to prevent the spread of HIV infection.

Submitted by:

Carl Berggren, M.A., R.C.

Darrel DuBois

Thomas Koberstein

Tia Plympton, M.S.W.

Paul Starr, M.S.W.

PUBLIC HEALTH MEASURES

Condoms

Issue

The HIV infection is transmitted in semen. Among men who participate in male to male sex, and female sex partners of infected men, semen is the primary mode of infection. At issue is whether the state should establish a mechanism to routinely supply condoms in an effort to reduce the transmission of HIV infection through semen.

Current Status

No health agency currently supplies condoms without charge or on a routine basis as a response to the HIV epidemic. Local health departments provide condoms on a limited basis to clients of family planning services. Condoms are readily available for purchase in the private sector. The Cascade AIDS Project (Portland) has made condoms and accompanying wallet-sized safer-sex information cards available on a donation-requested basis at public establishments patronized by gay and bisexual men. This program was initially funded through a grant from the United States Conference of Mayors Research and Education Fund (COMREF).

Recommendations

1. Health care providers in public and private sectors should encourage condom use in all situations where there is a possibility that infected semen may be transferred from one person to another. This recommendation may be applicable in institutional settings.

2. Encouragement of condom use should be in conjunction with other safer sex practice information.

3. Government and private health agencies should encourage private sector businesses with high risk clientle to increase the opportunity for condom purchase i.e., installing dispensing machines.

4. County public health departments should make condoms readily available to those people using their services or through community organizations doing outreach activities to high risk groups.

Rationale

Studies indicate that intact condoms provide protection against the transfer of the HIV infection from one person to another. To the extent that either cost or a lack of access reduces the use of condoms, the potential transmission of HIV infection increases. The economic and human cost of that infection warrants public fund expenditures.

Budget Appropriation Required

Condom Purchase - $50,000 (This represents the maximum forecast as necessary. The minimum is $20,000.)

PUBLIC HEALTH MEASURES

Risk Site Regulation

Issue

Establishments exist where high risk sexual activities occur. Some jurisdictions outside Oregon have enacted regulations allowing local health officers to close establishments where these high risk sexual activities take place. At issue is whether either the Health Division Administrator or County Public Health Officers should exercise powers under ORS 433.106 to close such establishments.

Current Status

Neither the Health Division Administrator nor any County Public Health Officer has acted to close such establishments.

Recommendation

1. The Legislature should adopt the bill submitted amending ORS 433. See Appendix, page 104. It requires that any coercive regulation of risk sites is subject to the same due process and fair procedure protections that apply to quarantine.

2. Public health officials should adopt a policy reflecting that closure of high-risk establishments is almost never warranted.

3. The Health Division should assure that targeted educational information be made available at establishments where high risk sexual behavior occurs.

Rationale

Regulation of places where high risk groups engage in dangerous practices offers only questionable effectiveness in that unsafe sexual activities can occur in any semi-private place. It is more effective to use these places to disseminate information since they are congregation points for a segment of a high risk group.

Unless the public health benefits from closing bathhouses were extremely clear, this action would be constitutionally suspect. Access to bathhouses and similar sites of risky sexual activity invokes two constitutionally protected rights: freedom of association, and freedom of intimate personal relations. Given the present relatively low enforcement level of laws governing other forms of semi-public sexual behavior, closing bathhouses could readily be challenged as unlawful discrimination.

Budget Appropriation Required

Included in the budget for Current High Risk Groups under the Target Group Education Recommendation, page 51.

PUBLIC HEALTH MEASURES

Syringes/Needles

Issue

In the United States, recognized risk groups account for approximately 94 percent of reported AIDS cases. Of that group, approximately 25 percent are IV drug users. The HIV virus is transmitted through hypodermic needles and syringes since blood is drawn into the syringe during injection. At issue is, whether distribution of sterile syringes/needles to IV drug users is the most effective and appropriate response to this mode of HIV transmission.

Current Status

Currently no state agency provides sterile syringes/needles to IV drug users as a health measure in response to the HIV virus. Unlike some other states, Oregon pharmacies sell sterile syringes/needles without prescription.

Recommendations

1. The Committee recommends against state agencies distributing sterile syringes/needles for the purpose of reducing the transmission of the HIV virus.

2. All state and local agency personnel and private counselors working with IV drug users should educate them regarding HIV virus transmission through sharing hypodermic needles and encourage them to avoid such acts.

3. Public and private agencies should promote ready availability of sterile syringes and needles.

4. The Health Division should research and report on the costs of distributing sterile syringes and needles in relation to the benefits of disease prevention.

5. All pharmacies selling sterile syringes and needles should be required to enclose an information packet about AIDS. This should be accomplished by a cooperative effort of the Health Division and the pharmacy association.

6. The Health Division and others active in this area should strive to eliminate any barriers to the ready availability of sterile syringes and needles for purchase in pharamacies in Oregon. Educational outreach efforts to pharmacists regarding their role in stopping the transmission of HIV would be appropriate. This could be in conjunction with the Oregon pharmacist's organization.

Rationale

Promoting illicit drug use is contrary to the public policies against drug use. Nevertheless, recognizing that nearly one fifth (25 percent of 94 percent) of the AIDS epidemic is attributable to IV drug use, steps may be warranted to make IV drug use safer.

It is not known whether the cost of free distribution of syringes and needles can be justified in terms of disease prevention. There is, however, reason to believe that sterile syringes and needles are not always readily available. To that extent, easing availability of sterile syringes and needles could have a significant impact on the spread of AIDS.

On the other hand, syringes/needles are potential barter or sale items for drug users. To the extent this occurs, government funds could indirectly subsidize illicit drug use. In addition syringe/needle sharing is often part of the ritual aspect of IV drug use. Providing sterilized syringes/needles to IV drug users is not likely to affect this behavior.

Given the conflicting considerations and the public policy implications, Recommendations beyond the ones included in this Report require additional study.

Budget Appropriation Required

Research and report - $12,000

PUBLIC HEALTH MEASURES

Schools

Issue

HIV infection is not likely to be transmitted in the school setting, except in very unusual circumstances. On the other hand, many parents still fear that there is a risk of transmission in the school setting. School districts must, therefore, adopt policies about school attendance for children with HIV infections that effectively take into account the low risk of transmission and the public's fears. At issue is the procedure which should be used in public and private schools, grades K-12, to determine the conditions which allow a child with HIV infection, ARC or AIDS to safely remain there.

Current Status

Oregon Administrative Rule OAR 333-17-000(32) defines a "School Restrictable Disease" as "a disease which can readily be transmitted in a school setting and to which students and/or employees in a school may be particularly susceptible." AIDS is transmitted only by sexual contact, blood exposure of broken skin or mucous membranes, and from mother to fetus. It is not a disease for which cases should ordinarily be excluded from school.

Recognizing the degree of concern on the part of some parents, and the theoretical possibility that persons giving first aid to the bleeding injury of an HIV infectecd person could be exposed if basic precautions are not taken, the Health Division has issued AIDS-related guidelines for Oregon schools. See Appendix, page 131.) The guidelines recommend basic procedures to be followed in all instances of bleeding injuries. They also suggest that the school district superintendent form an ad hoc committee to determine whether and under what conditions an individual child with AIDS may attend school. The guidelines suggest that the child be briefly excluded from school while the committee formulates its recommendation to the superintendent.

The Committee believes these guidelines reflect good public health policy and satisfy the requirements of due process. The Committee particularly emphasizes the importance of proper first aid procedures for all bleeding injuries, because they provide special protection against the spread of the infection from the unidentified child with asymptomatic HIV infection.

Recommendation

1. Health Division should amend the guidelines for public schools to more clearly reflect the ultimate decision-making authority of the county health officer to exclude a child if that child poses a risk to others in the school setting.

2. The Health Division should amend the guidelines to more clearly reflect the ultimate decision-making authority of the school district to admit a child recommended for admittance by the county health officer.

3. Every public school district and every private school should adopt and implement either the Health Division policy or one which provides for individual determinations, based solely on sound public health policy. Policies should guarantee the student applicable constitutionally protected due process rights. The Committee envisions a prompt decision-making process, not to exceed two weeks, except in unusual circumstances outside the control of the school district.

4. Every local health department should either adopt and follow the Health Division policy or devise one which provides for individual determinations, based solely on sound public health policy, guaranteeing the student constitutionally protected due process rights.

Rationale

Denying a child access to school is a serious action. Permitting a child with AIDS to attend school requires a clear understanding of the measures necessary to protect the school community. The procedures schools and local health officers use in making such decisions must insure the rights of both the student and the school community, as well as reflect an educated response to AIDS.

Budget Appropriation Required - $0

EDUCATION/PREVENTION MEASURES

Target Group Education

Issue

Since neither a vaccine nor a cure for AIDS is expected in the next few years, the control of this epidemic must depend primarily on education. This education must inform those potentially at risk about how they can prevent exposure to the AIDS virus.

Providing information to the general public is important. The education must be thoughtfully designed and carried out in a manner that persuades individuals to take the necessary steps to avoid exposure.

Ideally every citizen should be educated regarding HIV infection, ARC and AIDS. In reality, it is not possible to educate all people concurrently, nor is it necessary to educate all people at the same level of detail. At issue is establishing the priority of identified groups for the purpose of providing appropriate information and the most effective method of targeting that educational effort.

Current Status

There has not been overall consensus and coordination regarding the precise composition of target groups for education. As a result of this lack of consensus, and significant underfunding, the current educational strategies are woefully inadequate.

Recommendation

Appropriate efforts should be targeted to the following groups, listed in priority order:

1. Current High Risk These are men who engage in male to male sexual activities, intravenous drug abusers, females who engage in sex with either high risk males or intravenous drug abusers and sexual partners of hemophiliacs. These groups are currently at high risk whether or not they have been diagnosed as HIV infected. Education of these groups is a top priority. Funding should be made available to community groups which are or can be successful in education efforts. The Health Division should supervise the contracts to such groups other than those providing services to drug abusers. Those should be supervised by the Alcohol and Drug Program.

2. Potential High Risk Three groups are at potential high risk. They include:
   - Prostitutes and those who engage in sexual activities with prostitutes
   - Sexually active, heterosexual, non-monagamous individuals
   - Youth whose sexual activities and possible drug abuse patterns are not yet defined.

Community organizations in communication with young people should be encouraged to provide AIDS education, using materials and resources developed by the Health Division or other organizations. School programs are a high priority for youth.

3. Service Providers This group is comprised of health care practitioners, dentists, police officers, firefighters, and social service providers. This group should be educated on the medical and emotional needs of HIV infected persons, procedures to prevent the spread of infection and the personal health practices HIV infected individuals should adopt to prolong their lives. Professional associations could be challenged to use their existing educational mechanisms to further this educational goal.

4. Current Low Risk These are monogamous or sexually inactive persons who are not illicit IV drug users. Currently, this portion of society has the lowest risk of HIV infection. This group is central in defining the overall social climate and social response to the AIDS epidemic. One effective way to reach this segment of society would be through the workplace. Even before a specific AIDS issue arises in the workplace, employers should be encouraged to conduct or sponsor educational efforts with their employees to promote understanding of persons with AIDS, ARC or HIV infection and reduce panic reactions. The more the current low risk group understands the medical, social and economic aspects of the AIDS epidemic, the more effectively this state can address them. See Appendix, page 136 for Workplace Guidelines.

Educational messages directed to the above groups should not be restricted solely to clinical and infection control issues. While persons with AIDS, ARC or HIV infection can participate in almost all social roles without risk of infecting others, fear and uninformed judgement can create an atmosphere in which persons with AIDS, ARC or HIV infection are inhibited from disclosing their condition even to essential medical or public health authorities. Elsewhere in this Report the Committee recommends legislation to protect confidentiality and the civil rights of persons with AIDS, ARC or HIV infection. It must be a specific educational goal to publicize the existence of these legal protections, and to promote the widest possible perception of safe and supportive clinical and social networks for the detection and management of HIV infection, ARC and AIDS.

Rationale

Educational efforts warrant the highest priority. Classifying characteristics into groups and ranking the groups in terms of priority better focuses additional funding and program efforts. Funding of community groups, with better access to the high risk population, can assure more effective education.

Budget Appropriation Required

Current High Risk Individuals - Budget incorporated in the "Preventive Services Budget, page 38.

Current High Risk Groups

1.	Contracts to community organizations for group education for high risk groups other than drug abusers.	$300,000
2.	Contracts to community groups for education of drug abusers.	33,000

Potential High Risk Groups, Service Providers and Low Risk Groups

1.	County Health Departments General education and targeted group education for potential high risk groups, service providers, and low risk groups	$375,850
2.	Health Division General Education and Targeted Group Education for Potential High Risk Groups, Service Providers and Low Risk Groups. Development of educational materials for use by private physicians, community organizations and health care providers Education of county AIDS trainers	$560,583
	TOTAL	$ 1,269,433

EDUCATION/PREVENTION MEASURES

AIDS Education Coordinating Committee

Issue

If the state of Oregon is going to address responsively and responsibly the HIV/ARC/AIDS epidemic, it must successfully identify and implement measures which provide maximum education of the highest quality to the population. The state of medical knowledge regarding HIV infection, ARC and AIDS changes rapidly. Other states and countries are experimenting with innovative methods of educating citizens. At issue is the method by which Oregon can best educate its citizens, whether they are persons with HIV infection, AIDS or ARC, health care providers, elected policymakers, community organizations or members of the general public.

Current Status

There is no one group in Oregon with the ongoing responsibility for statewide AIDS education and information.

Recommendation

The Health Division should appoint an AIDS Education Coordinating Committee. The role of this committee is to plan and prioritize educational needs and resources for Oregon, to advise the Health Division on the appropriate distribution of educational program funds to community organizations, and to report on AIDS related educational needs and services in the state of Oregon.

Membership of the AIDS Education Coordinating Committee should be limited to 15 and, at a minimum, consist of:

- One representative of the Department of Education
- The Health Division AIDS Program Coordinator
- Two physician members of the Oregon AIDS Task Force
- Two representative members of the community organizations active in AIDS educational services. (The Policy Committee visualizes that a coalition of community organizations could be formed to promote communication and coordination of services, and to select the two representatives for the AIDS Education Coordinating Committee)
- One person with AIDS and one person with ARC who have demonstrated skills and motivation related to AIDS educational services
- Two representatives of county health departments
- One nurse
- One attorney with expertise in civil rights law.

Appropriate geographic distribution should be taken into consideration when selecting representatives of community organizations, persons with AIDS or ARC and persons from county health departments.

The function of the AIDS Education Coordinating Committee is to:

- Identify significant research questions and data needs related to the overall educational task and submit them to appropriate bodies and organizations
- Communicate with other states and jurisdictions to assure that the best and most appropriate education on AIDS is available to the citizens of Oregon
- Confer with the Conference of Local Health Officers (CLHO) regarding distribution of funds to local health departments
- Advise and assist the Health Division in providing and coordinating statewide educational services
- Evaluate AIDS related educational needs and priorities for Oregon
- Identify the criteria for evaluating qualifications of community groups contracting to provide educational services
- Solicit the participation of organizations and community groups, when appropriate, to meet educational goals
- Recommend to the Health Division an appropriate AIDS education budget for distribution to community organizations
- Report regularly on the activities of the committee, and on the AIDS related educational needs, priorities and available services in Oregon.

Rationale

The implications of HIV infection are extensive in terms of scope and magnitude. To fragment responsibility for education at the statewide level is both inefficient and ineffective. One body must be the general resource point for the broad range of educational information available to meet the diverse needs of the population.

Budget Appropriation Required

Bi-monthly Meetings - $9,000

INSURANCE AND ACCESS TO CARE MEASURES

Health and Life Insurance

Issues

The existence of AIDS, ARC or HIV infection in an individual surfaces a number of concerns related to insurance. First is whether screening for AIDS, ARC or HIV infection is ever an appropriate tool in determining eligibility for group health or life insurance. Second is whether an insurer should be able to increase rates, not renew, or cancel a policy based on the claim experience of that policy. Third, is the appropriate use of an AIDS, or ARC diagnosis in underwriting. Fourth is the appropriateness of insurers using sexual orientation as a basis for any insurance related decision. Fifth is whether insurers issuing comprehensive medical, hospital or surgical policies should be permitted to exclude coverage for HIV infection, AIDS or ARC. Sixth is the advisability of an insurance risk pool. Seventh is the appropriateness of construing HIV infection as a pre-existing condition of ARC or AIDS. Eighth is the range of enforcement mechanisms necessary to assure insurer compliance.

This list of concerns is not a priority ranking, nor is it intended to be exhaustive. It reflects the areas initially identified by the HIV/AIDS Policy Committee and serves as a basis for the Recommendations that follow.

Current Status

Currently there is no Oregon statute or Insurance Division rule regarding the exclusion of AIDS or ARC in health insurance policies. Neither is there an Oregon statute or Insurance Division rule establishing the permissible effects of AIDS, ARC or HIV test results on obtaining either health or life insurance. In comparison, California, Wisconsin and District of Columbia do not permit insurers to use HIV antibody tests for underwriting purposes.

The Oregon Bureau of Labor considers AIDS, ARC and HIV infection handicap conditions for the purpose of enforcing laws prohibiting discrimination in empoloyment. This designation provides guidelines regarding screening for AIDS, ARC and HIV infection in terms of group insurance eligibility.

ORS 746.015 prohibits discrimination in insurance. The Oregon Supreme Court has held that because of this statute in the insurance code, the public accommodations law does not apply to insurance. However, the group insurance or self-insurance benefits that an employer provides for its employees would be considered terms and conditions of employment within the meaning of state employment discrimination laws.

No recommendation adopted under the insurance code would extend to employers providing insurance under "self-insured" arrangements, nor would it apply to Oregon residents covered by policies of multi-state employer's associations where the group policy was issued outside Oregon. Except for state insurance or tax laws, federal law (ERISA) pre-empts state laws governing welfare benefit plans. Pre-emption may result in state labor laws regarding discrimination being found insufficient to eliminate discrimination in group health insurance plans. For employer plans outside the reach of the insurance code, denial of the employer's state tax deduction could be a possible enforcement mechanism.

ORS 743.471 addresses cancellation of insurance. It permits an insurance company to cancel or adjust premium rates for an individual policy on the basis of its claim experience. Today few policies contain such a provision.

Recommendations

1. The Legislature should enact a statute prohibiting the use of HIV infection, ARC and AIDS screening in determining eligibility for group health insurance. The term "screening" includes, but is not limited to, reviews of past medical records or tests or requiring testing.

   Rationale

   Group premiums are based on the group's prior claims history. A person who is HIV seropositive may not experience increased medical costs at all, or may not experience them while covered under the group policy. As a result, the possibility of future health insurance claims, premised on HIV seropositivity, should not be sufficient to exclude an individual from coverage under a group plan.

   Budget Appropriation Required - $0

2. Absent more restrictive recommendations by the HIV/AIDS Policy Committee, based on those of Insurance Subcommittee, the Insurance Commissioner should promulgate administrative rules which limit screening for HIV infection, ARC and AIDS in individual insurance. Screening for these conditions is prohibited when not done in conjunction with screening for health conditions of comparable severity.

   Rationale

   For insurance purposes, HIV infection, AIDS and ARC do not differ from other serious medical conditions. As a result, no justification exists for singling them out for screening. Further, a failure to treat HIV infection, AIDS, ARC and other serious medical conditions similarly implies a de facto policy of unfair discrimination under ORS 746.015.

   Budget Appropriation Required - $0

3. The Insurance Commissioner should promulgate Administrative Rules assuring that as part of any health or life insurance procedure, an insurer may not use measures of any kind to determine an applicant's sexual orientation. (See Appendix, page 140 for the National Association of Insurance Commissioners (NAIC) Model Guidelines on Medical-Lifestyle Questions and Underwriting for AIDS.

   Rationale

   An applicant's sexual orientation is not a reliable tool in determining information necessary for health and life insurance purposes.

   Budget Appropriation Required - $0

4. The Insurance Commissioner should adopt Administrative Rules specifying minimum benefit standards under ORS 743.010(a) so as to require that all comprehensive major medical, hospital or surgical policies cover AIDS and ARC as they would any other serious medical conditions.

Rationale

Under comprehensive health insurance policies there is no justification for treating AIDS and ARC differently than other serious medical conditions.

Budget Appropriation Required - $0

5. The HIV/AIDS Policy Committee will submit additional insurance recommendations to the Legislature no later than April 30, 1987. As part of that process, by March 31, 1987, the Insurance Subcommittee will submit recommendations to the full Committee regarding the following issues:

- the use of AIDS, ARC or HIV test results as a basis for underwriting, increasing premiums, refusing to renew or canceling individual health or life insurance policies
- the development and implementation of a state risk pool as described in the Insurance Risk Pool Recommendation, page 58
- the appropriateness of considering HIV infection a pre-existing condition with respect to AIDS or ARC
- the value of adding new remedial provisions to the insurance code or extending public accomodation laws as enforcement measures.

The HIV/AIDS Policy Committee endorses certain guidelines for the Insurance Subcommittee to apply as it develops recommendations. These include:

- If an insurer may use HIV testing or an AIDS or ARC diagnosis in underwriting individual insurance, it may use the results, at most, to exclude costs arising from these conditions. The insurer may not use such information to deny issuing a policy covering other conditions
- HIV tests should not be permitted if they would be used as a de facto means of excluding individuals on the basis of sexual orientation
- Any HIV testing procedures must meet adequate standards for reliability
- Any restriction of insurance because of diagnosed ARC or AIDS should be based on a diagnosis by a qualified individual
- Insurers should not be permitted to cancel or individually increase premiums on an existing policy merely because the insured person is HIV infected or is diagnosed as having ARC or AIDS.

Rationale

The HIV/AIDS Policy Committee recognizes and appreciates the importance and complexity of issues in these areas of insurance regulation. Accordingly, prior to submitting recommendations to the Legislature, the Policy Committee recognizes a need for further and more in depth consideration. At the same time, the Policy Committee believes that the balance of recommendations in this report is of such importance it warrants immediate presentation to the Legislature.

Budget Appropriation Required - $0

INSURANCE AND ACCESS TO CARE MEASURES

Insurance Risk Pool

Issue

Estimates of medical costs attendant to AIDS or ARC range from $36,000 to $147,000. It is, therefore, of crucial importance for a person facing this magnitude of medical costs to be assured of stable third party coverage. The recommendations regarding the use of HIV testing and AIDS or ARC diagnosis to screen for insurance coverage, to cancel an existing policy or to increase premiums do not address the effect of no health insurance on an individual.

For persons with HIV infection, change in employment status can lead to the loss of group-rated health insurance. Although access to the group rate may be continued for up to 18 months through self-payment of premiums, it may often be that even these premiums become an impossible financial obligation for an unemployed person. Even if the premium for group-rated insurance can be met during the 18 month period, the price of individual insurance in the subsequent period is likely to be prohibitive.

The predicament described above highlights a characteristic of our health care financing system which regularly creates a class of persons who are initially uninsured and must spend themselves into poverty before they become eligible for Medcaid or General Assistance sponsored health services. This issue is broader than AIDS or ARC policy. It concerns many other forms of catastrophic illness.

Current Status

Despite initial Congressional efforts to require states to develop health insurance risk pool, the last Congress adjourned without taking action. The National Association of Insurance Commissioners has adopted a model Health Insurance Pooling Mechanism Act. Currently 11 states have established such pools. Oregon has not.

Recommendation

1. The HIV/AIDS Policy Committee endorses the concept of a statewide risk pool as a source of health insurance for persons with AIDS or ARC and other catastrophic medical conditions.

2. The Legislature should enact legislation creating a health insurance risk pool or an equivalent mechanism. It should be based on the HIV/AIDS Policy Committe recommendations.

3. The HIV/AIDS Policy Committee should submit recommendations regarding a health insurance risk pool or equivalent mechanism to the Legislature no later than April 30, 1987. Such recommendations should be based on those submitted by the Insurance Subcommittee.

4. The Insurance Subcommittee of the HIV/AIDS Policy Committee should submit recommendations regarding a health insurance risk pool or an equivalent mechanism to the full Committee no later than March 31, 1987. These recommendations should include consideration of state financed premiums.

5. If the Legislature does not complete action on indigent medical care this session, it should convene an interim task force on health insurance pooling.

Rationale

The psychological impact of having AIDS or ARC is a significant burden. It is the hallmark of a humane community to help alleviate at least the financial burdens attendant to serious illness. The American system of financing health services, which blends private insurance with government sponsored programs, regularly leaves a small but significant number of persons without reliable access to third party assistance in paying for needed medical care.

For example, persons with HIV infection, ARC or AIDS who are uninsured, and whose income falls slightly above the guidelines for Oregon's medically needy program must accumulate medical expenses equal to six times their monthly incomes before they are eligible for Medicaid services. The creation of a health insurance risk pool or some equivalent mechanism would help maintain continuous third party assistance for those who must face the psychologically devastating effects of AIDS or ARC or other catastrophic illnesses.

A risk pool mechanism is sufficiently important and complex to warrant further investigation prior to submitting specific recommendations to the Legislature. As a result, recommendations currently submitted express the HIV/AIDS Policy Committee's endorsement and agenda for assuring well reasoned recommendations in the risk pool area.

Budget Appropriation Required - $0

Note: A cost estimate for implementing specific recommendations will be submitted as part of the March 31, 1987 report to the HIV/AIDS Policy Committee and the April 30, 1987 report to the Legislature.

INSURANCE AND ACCESS TO CARE MEASURES

Access to Care

Issue

The HIV/AIDS Policy Committee believes that any person with HIV infection, ARC or AIDS should have access to appropriate medical and dental care within a reasonable distance of home. At issue is how best to assure such access.

Current Status

Access to hospital care has not been identified as a problem. There have been anecdotal reports regarding denial of access to physicians, long term care facilities and dentists. In addition, there are reports that some of those providers have charged for medically unnecessary services or overcharged for necessary services.

The Bureau of Labor has determined that persons with AIDS or ARC, or who test seropositive for HIV infection are handicapped under Oregon's civil rights laws. See Appendix, page 134. As a result, the Bureau of Labor will investigate complaints alleging denial of treatment or additional fee charges to determine if illegal discrimination has occurred.

Professional organizations significantly affect the standards and duties of care incumbent on health care providers. Those standards or duties are often reflected in codes of conduct or ethical cannons. They may be enforced formally or through peer pressure.

Use of common law and licensing statues to address the access issue depends on the classification of care (emergency or non-emergency) and the classification of the care provider (facility or individual). Common law, as well as licensure and Medicare statutes, requires hospitals to provide emergency care. Oregon's "good samaritan" statute, ORS 30.800, immunizes medically trained persons from most liability for malpractice or negligence in the course of providing emergency medical treatment. No law requires individual medical providers to give emergency care. No law requires either facilities or individual providers to provide non-emergency care.

Licensing Boards and the Health Division, Health Facilities Section are empowered to consider access as an issue in licensing actions. The Health Facilities Section may adopt Administrative Rules addressing access issues.

Recommendation

1. Upon receipt of a complaint alleging that extra charges have been imposed by any health care practitioner either to provide medically unnecessary services or as a result of a discriminatory desire not to provide health care services, the Health Division should convene a meeting with the appropriate professional association to devise a solution, and advise the person to contact the Civil Rights Division of the Bureau of Labor and/or the Governor's Citizens' Representative.

2. The Health Division should challenge health care practitioner groups to provide education to their members regarding the impact of HIV infection, ARC and AIDS on their work. (Refer to Target Group Education, page 49, for additional information.)

3. The Bureau of Labor should adopt Administrative Rules identifying which health care practitioners are governed by discrimination in public accommodation rules.

Rationale

Access to care is critical to a person with AIDS, ARC or HIV infection. Because of the public health implications of AIDS, ARC and HIV infection, access to care is also critical to the protection of the community. Access to medical care should not be limited or denied for unlawful discriminatory reasons. The cost of that care must reflect only those charges which are realistically related to the condition.

Historically health care professionals have been responsive to concerns expressed by their respective professional associations. If professional organizations are ineffective in addressing the problems arising in the access issue, actions which affect licensing or actions under the Public Accommodation Act may be warranted.

Budget Appropriation Required - $0

RIGHTS PROTECTION MEASURE

Informed Consent to Blood Testing

Issue

Blood tests can determine the presence of HIV infection. At issue is whether informed consent should be required for such HIV blood testing.

Current Status

Informed consent is a fundamental legal rule governing medical diagnosis and treatment. It allows every individual to decide what shall be done to his or her body. Without doubt, informed consent is required in order to draw a blood sample for testing, unless some legal exception applies. However, current law on informed consent is less clear regarding the tests to be run on a blood sample. Voluntary blood donors in Oregon sign a detailed form granting consent to HIV testing. When blood is drawn for other purposes, however, HIV blood tests have been run without the patient's consent.

ORS 677.097 specifies the procedure a physician or podiatrist must follow in obtaining informed consent. Some states (e.g. California) have required that consent to HIV testing be written, and others have statutorily required a specific disclosure form.

Case law on informed consent has developed a number of exceptions to the rule. For example, no consent is necessary when there is a medical emergency, when informing the patient would be medically damaging, when treatment is compulsory irrespective of consent, and when third parties are endangered. In addition, many rules have been developed regarding consent by representatives for those unable to consent for themselves, such as minors and the mentally incompetent.

Recommendation

1. The Legislature should enact a statute which prohibits the testing of blood for HIV infection except where the individual to be tested has specifically consented to HIV testing or case law exceptions apply. The statute should also grant the Health Division rule making authority regarding the procedures sufficient to establish informed consent to the blood testing for HIV infection.

2. Upon legislative authorization, the Health Division should initiate the rulemaking process. The rule(s) should require documented informed consent prior to any testing of an individual's blood for HIV infection. The rules should be subject to case law exceptions where consent is not necessary except for third party endangerment. That exception should be limited to situations where the third parties have no reason to expect they are at high risk of exposure. Reporting Recommendation 6 identifies these persons.

   The procedure in ORS 677.097 is adequate for HIV testing. Further, while it is desirable to document who informed the patient, there is no need for the statute to require the patient's signature or any particular form of disclosure.

Rationale

The law requires that an individual consent to the drawing of blood for testing. There is no medical consideration warranting less recognition of the right to consent to the tests to be run on it.

Budget Appropriation Required - $0

RIGHTS PROTECTION MEASURES

Blood Testing as a Condition of Employment

Issue

The Committee has received anecdotal information that some employers, responding to a fear of transmitting AIDS or ARC in the workplace, have considered requiring HIV blood testing as a condition for obtaining or retaining employment.

At issue is identification of the conditions under which such testing reflects sound public health policy.

Current Status

Currently no state or federal law specifically precludes employers from testing applicants or employees for HIV infection, ARC or AIDS. However, state and federal handicap discrimination laws discourage employers from such testing. Regulations under federal and state laws permit physical examinations of employees and applicants but prohibit adverse employment decisions based on handicap conditions (actual or perceived). See Employment Discrimination Recommendation, page 68.

Recommendations

1. The Health Division should, by rule, identify occupations where testing may be a bona fide condition of employment or an otherwise appropriate health measure.

2. The Bureau of Labor should clarify that its physical examination rules apply to testing for AIDS, ARC or HIV infection.

3. The Bureau of Labor should inform employers the occupations where testing for AIDS, ARC or HIV infection is permitted and that its physical examination rules apply to such testing.

4. In cases where testing is appropriate, persons expected to submit to testing must have prior notice of the test requirement and must give informed consent to such test. If testing is permitted as a bona fide condition of employment under Health Division rules, all persons employed in the identified positions must be subject to the testing.

Rationale

Any screening for HIV infection by blood testing is intrusive. A person's right to privacy must give way only in situations where protecting public health requires it. The Health Division is the appropriate agency to make such a determination.

Restricting the use of test results for employment decisions and requiring uniform testing assures that the procedure is used for protecting public health rather than, for example, confirming an employer's suspicion of an employee's sexual orientation or drug use.

Budget Appropriation Required - $0

RIGHTS PROTECTION MEASURE

Confidentiality of HIV Information

Issue

A breach of confidentiality by public or private health care providers, social service agencies or others with respect to information identifying a person as having HIV infection, ARC or AIDS can result in devastating consequences to the person infected. It also jeopardizes the credibility, and thus, effectiveness, of systems designed to stop the spread of the infection. The stigma of HIV infection, ARC or AIDS is sufficient in itself to cause many to be reticent to even seek education or counseling, much less testing. For many, fear of a breach in confidentiality is second only to the fear of having HIV infection, ARC or AIDS. As a result, assuring the confidentiality of HIV test results and related information is a mandatory prerequisite for any public health response to the AIDS epidemic. At issue is the adequacy of current confidentiality protections.

Current Status

Oregon's general policy on the confidentiality of medical records is embodied in ORS 192.525. It carries no penalty provisions for breach of confidentiality by public exposure.

Currently, under ORS 433, public health agencies, including the Health Division and county health departments, are forbidden to disclose the identity of any persons reported as having a communicable disease. There are no penalty provisions to enforce the statute.

California, Hawaii, Massachusetts and Wisconsin have enacted special statutes regarding confidentiality protections afforded to HIV related medical records. The Uniform Health Care Information Act also offers policy guidance.

Many, but not all, health care professions require state licensing. The licensing provisions often include confidentiality protections. There is no penalty for violation except license suspension. Because of the seeming harshness of the penalty, licensing laws are rarely used to take enforcement actions for breaches of confidentiality. Thus, not all health care providers are governed by licensing laws, and to the extent that they are, the licensing laws are not commonly used to enforce confidentiality provisions.

Funding source requirements and internal agency policies determine the confidentiality protections available to client records in private social service agencies. Thus, there is no uniformity of protection or enforcement mechanisms in these agencies.

Recommendations

1. The Legislature should enact a confidentiality statute prohibiting disclosure without consent of any medical information, including HIV test results, ARC or AIDS diagnosis. These statutes should apply equally to public agencies and the private sector.

2. The new statute should afford an array of remedies for unauthorized disclosure of protected medical information, including criminal penalties, civil penalities, licensure sanctions, and private actions.

3. The legislature should model such a statutory change after AIDS confidentiality statutes that have been enacted in other jurisdictions.

4. The new confidentiality statute should be in addition to the confidentiality requirements under ORS 433, the communicable disease reporting statute.

5. The statute should provide exceptions for disclosure in extraordinary situations, along the lines of ORS 179.505(10). There should also be an exception for communications necessary in order to make reasonable accommodations to handicapped persons.

6. Health and social service agencies in the public sector should have confidentiality policies and should ensure that these policies are enforced. Private sector social service agencies should be encouraged to develop similar confidentiality policies.

Rationale

All persons are entitled to privacy regarding their medical records. In the case of persons who seek HIV antibody tests or diagnostic assessments for ARC or AIDS that privacy is essential. Without it, the state compromises the effectiveness of its AIDS response strategy.

Budget Appropriation Required - $0

RIGHTS PROTECTION MEASURE

Employment Discrimination

Issue

At issue is whether current state statutory and policy provisions adequately address persons with AIDS, ARC or HIV infection in the workplace.

Current Status

The Bureau of Labor has determined that discrimination against persons with AIDS, ARC or HIV infection is unlawful under state handicap discrimination laws. (ORS 659.400 et. seq.) The Bureau considers AIDS, ARC and HIV infections to be actual or perceived handicaps under the definition of "handicapped" in ORS 659.400(2). See Appendix, page 84.

Recommendations

There is no need for further legislation regarding employment discrimination against persons with AIDS, ARC or HIV infection. The Bureau of Labor should continue to interpret state law as prohibiting discrimination on the basis of AIDS, ARC or HIV infection.

Rationale

There is neither a medical nor logical reason to exclude persons with ARC or HIV infection, or perceived as having AIDS, ARC or HIV infection, from being classified as handicapped. They are entitled to the same protection under the law as persons with other physical or mental handicaps.

Budget Appropriation Required - $0

RIGHTS PROTECTION MEASURE

Discrimination in Housing and Public Accommodations

Issue

As is true with obtaining and retaining employment, absent government protection against discrimination, persons with AIDS, ARC or HIV infection may be denied housing and access to public accommodations. At issue is whether such a denial is permitted in light of the current Bureau of Labor and Industries policy establishing AIDS, ARC or HIV infection as handicaps affording protection against discrimination in employment and public accommodations.

Current Status

The Bureau of Labor and Industries has recognized AIDS, ARC or HIV infection as actual or perceived handicaps for the purpose of preventing discrimination in employment. See page 84. The Bureau of Labor has indicated that it is appropriate to extend handicap protection to housing and public accommodation. See Appendix, page 86.

Recommendation

The Bureau of Labor and Industries should adopt Administrative Rules to make known, to the degree possible, those businesses and services that are public accommodations under the Oregon law and thus, may not discriminate on the basis of handicap conditions.

Rationale

There is no public health or social policy justification for treating persons with AIDS, ARC or HIV infection differently in employment, housing or public accommodation situations. Such persons are handicapped and entitled to protection against discrimination.

Budget Appropriation Required - $0

SUPPORTIVE SERVICE MEASURES

Treatment Expense Funding

Issue

Support services and medical care costs for AIDS patients from diagnosis to death vary depending on the mix of services provided and the geographic location of the patient. It is estimated that in Oregon the cost of the full range of services for this period is $50,000 per patient. Some of this expense may be covered by private insurance but state agency costs assume that at the time cases get to the stage of AIDS diagnosis the patients may have lost insurance benefits. At issue is the projected cost for the full treatment of AIDS patients for the 1987-89 biennium.

Current Status

Adult and Family Services Division and Senior Services Division are currently responsible for providing fund support for in-home care and various levels of hospitalization for AIDS patients. AFS will pay for 18 days of inpatient hospitalization for Medicaid clients and 12 days for General Assistance clients. This limitation creates an issue in a minority of AIDS patients, especially in the second and third year of the disease.

State funding through these agencies is less than hospital charges. Complete fiscal data regarding the state costs for these patients is not available.

Recommendation

The Legislature should allocate sufficient funds between Adult and Family Services and Senior Services Division to pay for the necessary medical and support services care for the projected AIDS caseload from 1987-89.

Rationale

Because of loss of work and depletion of personal resources, it is estimated that 50 percent of the projected AIDS patients will become eligible for state funded services.

Budget Appropriation Required*

$16,800,000 is to be allocated between Adult and Family Services and Senior Services Division based on the type of allowable expenditure category. This figure is based on the projected number of AIDS cases anticipated through 1989 (800) (Total number of AIDS cases through 1987-1989 biennium (1,600), less the number of AIDS cases living at the end of the biennium (592), less the cases diagnosed and dying during the biennium (208) equals 800 cases alive during the 1987-1989 biennium and needing care) multiplied by the cost per case ($50,000) less the number alive at the begining of the biennium (125) multiplied by the cost of each of those cases ($50,000). This figure is multiplied by the estimated percentage of AIDS patients unable to pay for treatment (.50). The $50,000 estimate is within the range of estimates used nationally and reflects the conservative estimate of the Health Division. In addition, as drugs become available costs may increase.

1989 =	$40,000,000	
1987 =	$ 6,400,000	
	$33,600,000	
	X.50	
	$16,800,000	**

* This does not include treatment expenses for ARC.
** This figure is not adjusted for potential insurance payments. Estimates of such coverage are not available.

SUPPORTIVE SERVICE MEASURES

Case Management Contracts and Support Services Coordination

Issue

While the designation of a staff member in the Office of the Citizen's Representative (see page 78) will help alleviate many problems, other critical service needs remain. First, there is a need for advocacy of programs for persons with AIDS/ARC as a group. Second, it is necessary to coordinate and network the existing statewide services. Third, once a person with AIDS or ARC requires assistance from state agencies or community organizations, an ongoing case management system is necessary to identify current and anticipated needs, and coordinates available local resources. At issue is the best method to address these service needs.

Current Status

None of these needs is being adequately met on a continuing basis for all persons with AIDS or ARC.

Recommendations

1. The Department of Human Resources, with the assistance of a representative committee, should review the operations of agencies providing support services to persons with AIDS or ARC. The function of this committee is similar to that of the Education Coordinating Committee. Specifically, it should seek appropriate ways to achieve networking and coordinating existing services, assuring client access to them, and advocating for the expansion of services, as well as the development of needed services. The Department of Human Resources should determine where it is most feasible to carry out these functions, however, it is essential that staff with sufficient authority be clearly designated to carry out these responsibilities.

2. The Department of Human Resources should contract with public or private agencies, meeting standards for efficiency and effectiveness, to provide coordinated, ongoing case management services, as necessary, for persons with AIDS or ARC.*

   Case management services include:

   1. Assessing a broad range of client needs, (including but not limited to: general health care, psychological, financial, residential and employment)

   2. Working with public agencies (Adult and Family Services, Senior Services, Social Security, Office of Citizens' Representative, local government agencies), private agencies, and volunteers to meet client needs

   3. Monitoring client needs on an ongoing basis

   4. Troubleshooting for clients.

Rationale

The Department of Human Resources (DHR) has within its jurisdiction a number of agencies which already serve persons with AIDS or ARC. One of the tenents underlying the existence of DHR is that more effective service can be delivered to people at less cost, if there is an umbrella agency to coordinate. Thus, DHR is the ideal agency to be responsible for such coordination of services.

Budget Appropriation Required - $3,600,000

The cost of managing an AIDS patient through the illness would depend on factors of whether existing systems or separate new systems are used. The existing systems would treat a patient the same as any other client of the supporting agency. Based on an estimate of 1,200 cases through the 87-89 biennium with 800 still alive at the end of the biennium, $2,400,000 for staff and at least one half the same in services and supplies ($1,200) is necessary for a total of $3,600,000. This makes the assumption that each staff member can have a caseload of 30 at a time. With a total of 800 cases to manage, this yields a need of 26.66 case managers, and at a cost of $90,000 per biennium per manager.

* An excellent model for this type of program is described briefly in the AIDS Task Force Report to the Mayor of San Francisco. The public sector has contracted with community-based agencies to provide the following services: psychological support, assistance with the activities of daily living, (transportation, shopping, cleaning, etc.), low-cost, permanent housing, public education, an AIDS Hotline, home health care and psychotherapy/counseling.

SUPPORTIVE SERVICE MEASURES

Adult and Family Services Procedures

Issue

Persons with AIDS or ARC inevitably require medical services. Adult and Family Services Division (AFS) provides financial assistance for medical services under Medicaid and GA (General Assistance). At issue is the appropriateness of current AFS confidentiality/privacy and eligibility procedures and policies regarding persons with AIDS or ARC.

Current Status

Persons with AIDS or ARC often apply at Adult and Family Services local offices for assistance. There are anecdotal reports concerning a lack of privacy in those offices. AFS has policies regarding privacy at reception and interview areas, and continues its efforts to assure adequate privacy.

Adult and Family Services administers the state funded General Assistance (GA) program. It is designed as a short term disability program. Persons with ARC are eligible for GA if a physician certifies they are unemployable for at least 60 days. Persons receiving GA must provide written medical evidence of unemployability for each period of eligibility, usually 60 days. This process is known as recertification. It does not apply to persons with AIDS. They are eligible for Medicaid Title 19 programs which do not require recertification every 60 days.

Recommendations

1. Adult and Family Services should continue to take necessary measures to insure confidentiality of information at all AFS sites.

2. Adult and Family Services should assure privacy at reception and service areas in local offices.

3. At the initial intake interview Adult and Family Services staff should provide a list of all documents that will be needed by the AFS staff.

4. Adult and Family Services should provide simplified recertification procedures for persons whose disability will last for longer than 60 days. AFS staff should make this process known and more readily available to treating physicans as well as clients with chronic disability conditions. Telephone recertification should be used to lessen the burden on debilitated clients.

5. Adult and Family Services should continue to provide appropriate staff with necessary AIDS/ARC education.

Rationale

Because of the sensitive nature of AIDS and ARC, persons requesting financial assistance for medical services have a legitimate expectation of privacy regarding their medical condition. This extends to the verbal and written information required by Adult and Family Services. As a result, privacy in reception areas, in interview areas and with respect to documents warrants special attention.

By providing a listing of required documents at the initial interview, Adult and Family Services will be able to make eligibility decisions more efficiently. The benefit accrues to both the citizen and Adult and Family Services, by time savings to both.

Requiring a recertification of continuing disability every 60 days for a person with ARC is unrealistic in light of the degenerative nature of the medical condition. The requirement causes unnecessary costs for processing the recertifications.

The better educated AFS staff is regarding the issues involved in providing services to persons with AIDS or ARC, the more efficiently the services can be delivered. The more efficient the services are, the less cost there is in providing them.

Budget Appropriation Required - $0

SUPPORTIVE SERVICE MEASURES

Dental Care Through Adult & Family Services

Issue

AIDS and ARC are diseases which suppress the immune system. That makes preventive dental care and treatment essential. As a result, a dental condition which may not be an emergency in most persons could be an emergency to immunosuppressed persons, including those with AIDS or ARC.

The emergency nature of some dental conditions and the fact that immunosuppressed persons with AIDS or ARC reside throughout the state make it essential that all dental care providers are educated in the effects of AIDS and ARC. At issue is the best method of assuring dental care providers are educated in the implications of AIDS and ARC in dental treatment.

In cases where persons with AIDS or ARC need dental care and are eligible for financial assistance for that dental care from Adult and Family Services Division, appropriate care is contingent upon the accurate determination of the nature of the service. At issue is how Adult and Family Services Division personnel can best identify those dental conditions for persons with AIDS or ARC which qualify for payment because of their emergency nature.

Current Status

Dental health care providers have not been uniformly educated as to the effects of AIDS or ARC on dental conditions. As a result, persons with AIDS or ARC with certain dental conditions may not be receiving treatment consistent with their dental needs, in that the conditions are not recognized as emergencies. The AFS Dental Program provides only emergency dental care for adults. Failure to classify treatment of the conditions listed in the Appendix as emergency in nature can preclude AFS payments. For a list of conditions which may be emergencies for persons with AIDS or ARC, see Appendix, p. 139.

Recommendations

1. Adult and Family Services Division should clarify its dental payment policies to reflect coverage of the identified dental care for immunosuppressed persons, including those with AIDS or ARC, as emergency care.

2. Adult and Family Services Division should distribute to all dental care providers in Oregon information relevant to dental conditions of persons with AIDS or ARC, including the list of conditions appropriate for payment coverage as emergencies under AFS rules.

3. As referenced in the Target Group Recommendation, the professional organizations for dental care providers could be challenged to incorporate HIV, ARC and AIDS information into their continuing education programs.

4. Health care practitioners and community agencies providing services to persons with AIDS or ARC should advise them about the need for preventive dental care and the effect of AIDS or ARC on dental conditions.

Rationale

Adult and Family Services Division staff is in ongoing contact with numerous dental care providers. Thus it is in the best position to educate them regarding the proper reporting procedures for AFS payment. The change of classification of the identified dental conditions to emergencies makes it reflective of the true nature of the conditions in persons with AIDS or ARC.

Budget Appropriation Required

Information development and mailing costs - $6,000

No specific data currently available regarding potential AFS Dental Program costs.

COORDINATION MEASURES

Governor's Office-Citizens' Representative

Issue

Persons with AIDS or ARC need a variety of health care and support services. State and local government agencies, private non-profit agencies and other organizations provide a range of resources.

Often a lack of information regarding the availability of help prevents a person with AIDS or ARC from receiving needed services. In other instances, misinformation will result in the person with AIDS or ARC being denied available assistance. Rules and regulations governing eligibility for services or dictating limitations on services may not have been amended to address issues unique to the needs of people with AIDS or ARC.

Health care providers and community organizations face the same issues regarding information, misinformation and obsolete regulations that face persons with AIDS or ARC. At issue is determining the most efficient and effective method of providing a central accessible resource for information and conflict resolution.

Current Status

The Citizens' Representative and staff work out of the Governor's office. The group functions to provide information, investigate citizens complaints and where possible, negotiate solutions to problems arising from a citizen's interaction with a state agency. The Governor selects the Citizens' Representative, who, in turn, selects staff. Until recently, no one in the Citizens' Representative's office was specifically educated in the needs of persons with AIDS or ARC, or the programs available through state agencies.

Recommendation

The Citizens' Representative should designate a staff member to act as a resource for AIDS/ARC services information, and an advocate for persons with AIDS or ARC who require services. Specifically, this staff member should:

1. Establish and maintain resource files on all known government and community services (formal and informal) germane to the needs of persons with AIDS or ARC

2. Provide information and referral service

3. Maintain up-to-date information concerning eligibility requirements, procedures, and services available through state agency programs

4. Facilitate client access into state agency programs

5. Advocate for persons with AIDS or ARC on a case-by-case basis when there is an opportunity for specific case resolution leading to program improvement

6. Evaluate and monitor ongoing services provided by state agencies

7. Identify trends and recommend development of needed services to the Governor and legislature.

Rationale

Placing responsibility in the Office of the Citizens' Representative assures centralized access at an agency traditionally associated with providing information, resolving problems and advocating for citizens in need. As part of the Governor's staff, the Citizens' Representative may often be able to act more effectively on behalf of citizens than staff of state departments or divisions or local community agencies.

Budget Appropriation Required - $0

COORDINATION MEASURES

HIV/AIDS Policy Committee

Issue

The AIDS epidemic is relatively new in Oregon. Neither its direction nor scope of effect is certain. Much will depend on executive and legislative decisions regarding policy and funding. Much will depend on the choices individual citizens make regarding their health practices. Yet, there remains a degree of uncertainty as Oregon faces this new threat to its medical, economic and social health. As the epidemic evolves, issues may arise which are beyond those identified and addressed in this Report. At issue is whether there is a need to maintain a statewide policy committee to develop policy and program recommendations as new HIV/AIDS issues arise.

Current Status

The Emergency Board requested that the HIV/AIDS Policy Committee prepare and present a report addressing the current issues HIV/AIDS has surfaced and to make policy, program and budget recommendations. The Committee completes that work as it submits this Report. Currently there is no legislative basis for continuing the Committee.

Recommendations

1. The Legislature should continue to expect the Department of Human Resources to extend the term of the HIV/AIDS Policy Committee.

2. Health Division should convene the HIV/AIDS Policy Committee at least quarterly and whenever issues arise regarding HIV, ARC or AIDS which significantly affect state policies or programs.

3. The HIV/AIDS Policy Committee should regularly receive reports from the Education Coordinating Committee (see page 52) and the Committee working with Department of Human Resources (see Recommendation 1, page 72).

4. The Health Division should regularly furnish the HIV/AIDS Policy Committee with reports monitoring progress and implementing the Recommendations of this Report.

Rationale

There is no other body of diverse representation mandated to address the range of potential statewide issues that may surface as a result of the AIDS epidemic in Oregon. The best protection and use of this state's human and financial resources requires such a mechanism.

Budget Appropriation Required

Meeting/Report Costs - $5,000

APPENDIX

TEST RESULTS IN HIGH RISK V. LOW RISK POPULATIONS

The following example demonstrates how a larger percent of the positive results of a test will be false in a low risk population than in a high risk population.

Assume that a test will be positive in all persons who are infected, and that it will be falsely positive in only 0.1 percent of persons who are not infected. This excellent test is then used in two populations. One is a high risk group in which 20 percent are infected. The other is a low risk group in which only 0.1 percent are infected. The tables show the results in each group.

TABLE I

Test results in a group of 100,000 high risk people (20 percent or 20,000 are infected).

		TEST RESULTS		
		POSITIVE	NEGATIVE	TOTAL
Disease	Present	20,000	0	20,000
	Absent	80	79,920	80,000
	TOTAL	20,080	79,920	100,000

In this group, a very high percentage of the positive test results ($\frac{20,000}{20,080}$ = 99.6 percent) are from people who actually have the disease. In other words, only a very small percent of the positive test results will be in "false positives."

TABLE 2

Test results in a group of 100,000 low risk people (0.1 percent) or 100 are infected.

		TEST RESULT		
		POSITIVE	NEGATIVE	TOTAL
Disease	Present	100	0	100
	Absent	100	99,800	99,100
	TOTAL	200	99,800	100,000

In this group, very few individuals have positive test results. However, of those that are positive, only 50 percent ($\frac{100}{200}$) actually have the disease. This means that of the 200 positive tests, 50 percent are false positive.

This statistical effect means that a positive test result has a different meaning for a high risk person than for a low risk person. In this example, the high risk person with a positive test has a 90 percent certainty that he or she is actually infected. On the other hand, the low risk person with a positive test has only a 50 percent certainty that he or she is actually infected.

BUREAU OF LABOR AND INDUSTRIES
Mary Roberts, Commissioner

March 13, 1986

James M. Campbell
Attorney at Law
474 Willamette, Suite 303
Eugene, OR 97401

Re: AIDS and disability discrimination: Ur letter dated 2-28-86, received 3-4-86.

Dear Mr. Campbell:

This will acknowledge and thank you for the informative letter in caption.

Your view on the problems in employment associated with HTLV-III infections, generically referred to as "AIDS", closely mirrors the current policy of the Civil Rights Division of the Oregon Bureau of Labor and Industries. We have adopted the rationale, as early as mid-1985, that adverse employment decisions by an employer based on the mere suggestion of infection with the virus would allow the offended employe to file with us under ORS 659.425. This opinion is based on Oregon Administrative Rules 839-06-200 to 839-06-255 (copy enclosed) which outlines the Division's interpretation of the statute. It is also based on available medical opinion respecting the risk and manner of transmission and the degree of disablement involved.

On February 27th, W. W. Gregg, Civil Rights Division's Quality Assurance Manager, acted as local discussion leader at Willamette Univerisity Law School in connection with the American Law Institute-American Bar Association Video Law Review closed circuit telecast on "AIDS and the Law." Willamette was one of 43 viewing sites nationwide. Professor Leonard, whom I note you have copied with your letter, was one of the video presenters. Claudia Welch, RN, who works with Dr. McAllister, was discussion co-leader.

The enclosed rules have been in effect since January, 1984; to date the Division has not promulgated any general announcement regarding AIDS. The Division has consistently answered inquiries from the employer community as well as from potential complainants to the effect that an adverse employment decision based on AIDS, ARC, or a sero-positive finding known to the employer would be a violation. Such a decision based on a perception that the individual employe or applicant is a member of a high risk group, and is therefore "treated by an employer.... as having an impairment" (ORS 659.400 (3)(c)(C) defining ORS 659.425 (1)(i) would also be a violation. We believe

that no special rules regarding AIDS are necessary given the statute and existing rules. Thank you again for your interest.

Very truly yours,

CIVIL RIGHTS DIVISION

Johnnie M. Bell

Johnnie M. Bell
Administrator

Enclosure:

cc: Cascade AIDS Project
Kristine Gebbie, Oregon Health Division Director
Professor Arthur S. Leonard, Esq.
Robert O. McAlister, Oregon AIDS Program Coordinator
Ben Merrill, Esq.
Abby Rubenfeld, Esq., LLDEF
Bev Russell, Supervisor, BL&I/CRD Eugene
Benjamin Schatz, Esq., NGRA
Willamette AIDS Resource Council

JMB:lof

BUREAU OF LABOR AND INDUSTRIES
Mary Roberts, Commissioner

October 28, 1986

TO: HTLV-III AIDS Policy Committee

FROM: Johnnie Bell, Administrator
Civil Rights Division

RE: Health Division/Bureau of Labor & Industries Meeting
Regarding Handicap Discrimination

This memo will confirm our understanding of the meeting held between Ted Falk, Larry Foster, David Fleming and Bureau representatives on October 15, 1986. In order to provide handicapped individuals the fullest protection under the Bureau's Civil Rights laws, the Civil Rights Division agreed to amend its Administrative Rules to cover handicap discrimination in housing and public accommodation.

I concur with Ted Falk's assessment of the meeting as specified in his memo of October 15, 1986.

cc: Ted Falk
Larry Foster
David Fleming
Marilyn Coffel
Bill Gregg

PORTLAND
1400 SW 5th Avenue
Portland, Oregon 97201

SALEM
3865 Wolverine St. NE; E-1
Salem, Oregon 97310

EUGENE
165 E. 7th Street, Suite 220
Eugene, Oregon 97401

MEDFORD
700 E. Main
Medford, Oregon 97504

COOS BAY
320 Central Ave., Suite 510
Coos Bay, Oregon 97420

BEND
1230 NE Third, Suite A244
Bend, Oregon 97701

PENDLETON
700 SE Emigrant, Suite 240
Pendleton, Oregon 97801

COUNTY PERSONNEL RESPONSIBLE FOR
HIV COUNSELING AND TESTING

NOVEMBER 14, 1986

BETH BAGGERLY — 523-6414 x225
Baker County Health Department
2610 Grove Street
Baker OR 97814

JUDY LADD — 757-6835
Benton County Health Department
530 N.W. 27th Street
Corvallis OR 97330

CAROL HILLS — 655-8471
Clackamas County Health Department
1425 So Kaen Road
Oregon City OR 97045

SHARON RICHARDS — 325-8500
Clatsop County Health Department
P.O. Box 206
Astoria OR 97103

KAREN LAHD — 397-4651
Columbia County Community Health
520 Columbia Blvd.
St. Helens OR 97051

CARMINE PUGH — 756-2020 X510
Coos County Health Department
Courthouse
Coquille OR 97423

BARBARA IRWIN — 447-5165
Crook County Health Department
203 North Court Street
Prineville OR 97754

LOUISE LE CLAIR 247-7019
Curry County Health Department
P.O. Box 746
Gold Beach OR 97444

PHILLIS WEBB 388-6616
Deschutes County Health Department
409 N.E. Greenwood
Bend OR 97701

SUSAN MOYER, R.N. 440-3500
Douglas County Health Center
621 West Madrone
Roseburg OR 97470

Gilliam County Medical Center
422 North Main
Condon OR 97823

CLAUDIA EVANS, R.N. 575-0429
Grant County Health Office
P.O. Box 70
Canyon City OR 97820

JANET MOSELY 573-2271
Harney County Health Office
P.O. Box 551
Burns OR 97720

RACHEL SEIFERT 386-1115
Hood River County Health Department
1109 June Street
Hood River OR 97031

TOM ROBERTS 776-7300
Jackson County Health Department
1313 Maple Grove Drive
Medford OR 97501

STAN VILIUS 475-2266
Jefferson County Health Department
357 Sixth Street
Madras OR 97741

SUSAN GOODMAN 474-5325
Josephine County Health Department
714 N.W. "A" St.
Grants Pass OR 97526

CHERYL ESPENLAUB 882-8846
Klamath County Health Services
3300 Vandenberg Road
Klamath Falls OR 97601

PAT DESHAZER 947-3373
Lake County Health Office
712 Center Street
Lakeview OR 97630

STEVE MODESITT 687-4041
Lane County Community Health & Social
Services Department, Lane County Annex
135 East 6th Street
Eugene OR 97401

JUDY WILSON 265-6611 X212
Lincoln County Health Department
255 S.W. Coast Hwy
Newport OR 97365

JEANETTA SIMONIS 967-3888
Linn County Department of Health Services
Courthouse Annex
Albany OR 97321

GAY MORINAKA 889-7279
Malheur County Health Office
Courthouse
Vale OR 97918

MARIAN BAKER 588-5357
Marion County Health Department
3180 Center St., N.E., Rm 200
Salem OR 97301

PAT WRIGHT 676-5421
Morrow County Health Office
430 Heppner/Lexington Hwy
PO Box 799
Heppner OR 97836

VIC FOX 248-3700
Multnomah County Department of
Human Services
426 S.W. Stark, 7th floor
Portland OR 97204

MARGE COLTON 623-8175
Polk County Health Department
Courthouse - Room 102
Dallas OR 97338

SUE CAMERON 842-3413
Tillamook County Health Office
Courthouse
201 Laurel Avenue
Tillamook OR 97141

SHARON KLINE 276-3211
Umatilla County Health Department
431 S.E. Third
Pendleton OR 97801

CHERYL MILLER 963-1015
Union County Health Department
Courthouse
La Grande OR 97850

MARY LOU BRINK 426-3627
Wallowa County Health Department
P.O. Box 272
Enterprise OR 97282

CARLA CHAMBERLAIN 296-4636
Wasco-Sherman County Health Department
400 East Fifth Street
Courthouse Annex A
The Dalles OR 97058

JOYCE WESTBY & JOAN DERRY 648-8881
Washington County Health Department
265 S.E. Oak
Hillsboro OR 97123

Wheeler County Health Office
c/o Asher Clinic
P.O. Box 307
Fossil OR 97830

PAT BILODEAU 472-9371 X555
Yamhill County Health Center
412 North Ford Street
McMinnville OR 97128

RESOURCE DIRECTORY

Introduction

The agencies listed in this Resource Directory offer educational programs/material and/or support services related to HIV infection, ARC and AIDS. Members of the HIV/AIDS Policy Committee and Health Division staff have provided the information. Services information has been included where known. The agencies are listed in groups under the following headings: Community Based Organizations, Medical Screening, Home Health Agencies and Health Care Professional Associations.

COMMUNITY BASED ORGANIZATIONS

CASCADE AIDS PROJECT
408 S.W. 2nd Ave., Suite 420
Portland, OR 97204
503/223-5907

CONTACT PERSON: Tia Plympton or Paul Starr
SERVICES PROVIDED: Educating and training groups and individuals regarding AIDS and specifically risk reduction, also providing emotional and practical support services for diagnosed individuals, their families and loved ones.

COALITION FOR AIDS EDUCATION
3231 S.E. 50th St.
Portland, OR 97206
503/229-5792

CONTACT PERSON: Claudia Webster
SERVICES PROVIDED: Designing and presenting special education programs for groups expressing an interest.

COUNSELING CENTER FOR SEXUAL MINORITIES
SERVICE PROVIDED: Telephone referral assistance from 7 pm until 11 pm
503/228-6785

ECUMENICAL MINISTRIES
0245 S.W. Bancroft Street, Suite B
Portland, OR 97201
503/221-1054

SERVICES PROVIDED: Educating the religious leadership and encouraging pastors to cooperate with service organizations.

This information current as of 10/1/86

GAY AND LESBIAN ALLIANCE
P.O. Box 813
Roseburg, OR 97470-0166
503/672-4126

KAISER PERMANENTE HEALTH GROUP
503/280-2000 (Information Center)

SERVICES PROVIDED: Weekly group meeting arranged by Jean Monohan, M.S. in Health Center East Medical Offices, 3414 N. Kaiser Center Drive, Portland, OR 503/249-8555, Ext 3063

Home health/hospice program--not necessarily specific to AIDS/ARC, but available to them.
CLINICAL IMMUNOLOGIST: Robert Lawrence, M.D.
CLINICAL ONCOLOGIST: J. Thompson Leimert, M.D.

MEN'S RESOURCE CENTER
2036 SE Morrison
Portland, OR 97214
503/235-3433

SERVICES PROVIDED: Individual and group counseling for men.

METRO CRISIS CENTER
503/223-6161 or 503/658-8636
SERVICES PROVIDED: 24 hour emergency phone counseling

METROPOLITAN COMMUNITY CHURCH
1644 N.E. 24th Avenue
Portland, OR 97232
503/281-8868

CONTACT PERSON: Rev. Gary Wilson
SERVICES PROVIDED: Individual counseling involving spiritual issues, support counseling around death and dying issues, funeral and memorial planning and services, limited food resources available to those in need.

METROPOLITAN COMMUNITY CHURCH
P.O. Box 12961
Salem, OR 97309

METROPOLITAN COMMUNITY CHURCH
Eugene, OR
503/485-3665

This information current as of 10/1/86

MID-OREGON AIDS/HEALTH/EDUCATIONAL SUPPORT SERVICES, INC.
1115 Madison Street N.E., Suite 510
Salem, OR 97301
503/363-4963
503/738-3731 (Coastal contact number)

CONTACT PERSON: Carl Berggren, Dave Fletcher, or C.J. Jones
SERVICES PROVIDED: Educating and training individuals in other community organizations, providing community hotline services, reviewing and making case recommendations for volunteer workers, and initiating and/or participating in public meetings to provide health and risk reduction information.

MID VALLEY ACTION COMMITTEE
P.O. Box 1615
Eugene, OR 97440
503/687-9226

CONTACT PERSON: Scott Siebert, Chair
SERVICES PROVIDED: anonymous HIV antibody testing, clothing exchange, HIV positive support group, and advocacy services.

OREGON HEMOPHILIA ASSOCIATION CENTER
Oregon Health Sciences University
707 S.W. Gaines Road
Portland, OR 97201
503/225-8716

SERVICES PROVIDED: Education and counseling for hemophilia patients and their families

PHOENIX RISING
408 S.W. 2nd Avenue
Portland, OR 97204
503/223-8299

SERVICES PROVIDED: Counseling services for gay men and women.

PORTLAND AREA BUSINESS GROUP ON HEALTH
Portland Chamber of Commerce
221 N.W. 2nd Avenue
Portland, OR 97231
503/228-9411

This information current as of 10/1/86

SHANTI IN OREGON, INC.
113-B West 6th Avenue
Eugene, OR 97402
503/342-5088

CONTACT PERSON: Rev. Ken Storer, Project Coordinator
SERVICES PROVIDED: Emotional support program for persons affected, either directly or indirectly, with AIDS or ARC including counseling in pain management, wellness programs and death and dying; support groups for persons with AIDS or ARC, significant others and care givers.

WILLAMETTE AIDS RESOURCE COUNCIL
P.O. Box 5388
Eugene, OR 97405

SERVICES PROVIDED: Safe sex education, special outreach to drug abusers, information to medical and health care communities, network with attorneys.

This information current as of 10/1/86

MEDICAL SCREENING

ALL COUNTY HEALTH DEPARTMENTS

ALL AMERICAN RED CROSS OFFICES (as part of screening blood donations)

GOOD SAMARITAN HOSPITAL AND MEDICAL CENTER
Primary Care Unit
(503/229-7074

MULTNOMAH COUNTY HEALTH SERVICES DIVISION
SEXUALLY TRANSMITTED DISEASE CLINIC
503/248-3816

OREGON HEALTH SCIENCES UNIVERSITY HOSPITAL AND OUTPATIENT CLINIC - INFECTIOUS DISEASE CLINIC
3181 S.W. Sam Jackson Park Road
Portland, OR 97201
503/225-7735

ST. VINCENT HOSPITAL AND MEDICAL CENTER
9205 S.W. Barnes Road
Portland, OR 97225
503/229-2389

SUBURBAN MEDICAL CLINIC
503/256-3225

This information current as of 10/1/86.

HOME HEALTH AGENCIES

ALBANY HOSPITAL AT YOUR DOOR
1046 W. Sixth Street
Albany, OR 97321
503/926-2244 Ext. 265

CONTACT PERSON: Carol Morgan, Judi Low
AREA: 30 mile radius
SERVICES: Nursing, Home Health Aide, Physical Therapy, Speech Therapy, Occupational Therapy, Medical Social Service, Respiratory Therapy, Nutrition

BENEDICTINE CENTER HOME HEALTH
540 Main Street
Mt. Angel, OR 97362
503/845-6841 Ext. 56

CONTACT PERSON: Pat Erickson
AREA: 30 mile radius
SERVICES: Nursing, Certified Nursing Assistant, Home Health Aide, Physical Therapy, Speech Therapy, Occupational Therapy, Medical Social Service, Nutrition, Hospice, Clerical, Counseling, Medical Supplies

BENTON COUNTY HOME HEALTH
530 NW 27th
Corvallis, OR 97330
503/757-6835

CONTACT PERSON: Marie Bucolo
AREA: Benton County
SERVICES: Nursing, Home Health Aide, Physical Therapy, Speech Therapy, Occupational Therapy, Medical Social Service, Clerical, Counseling, Medical Supplies

C & N HOME HEALTH CARE, INC.
932 Klamath Avenue
Klamath Falls, OR 97601
503/882-7761

CONTACT PERSON: Beverly Fading
AREA: Klamath Falls & Vicinity
SERVICES: Nursing, Home Health Aide, Physical Therapy, Speech Therapy, Occupational Therapy, Medical Social Service, Clerical, Patient Counseling, Accounting

This information current as of 10/1/86

CENTRAL OREGON HOME HEALTH AGENCY
1900 N.E. Hwy. 20
Bend, OR 97701
503/382-5882

CONTACT PERSON: Craig Riley
AREA: 40 mile radius
BRANCH OFFICE: Prineville
ADDITIONAL NURSING OFFICE: Redmond
SERVICES: Nursing, Home Health Aide, Physical Therapy, Speech Therapy, Occupational Therapy, Medical Social Service, Homemakers, Private Nursing, Ambulance and Wheelchair Vans for Non-emergent Transport

CLACKAMAS HOME HEALTH
16207 SE McLoughlin
Milwaukie, OR 97267
503/654-1587

CONTACT PERSON: Margaret Rickles
AREA: Clackamas County
SERVICES: Nursing, Home Health Aide, Physical Therapy, Speech Therapy, Occupational Therapy, Medical Social Service, Clerical, Medical Supplies

CLATSOP COUNTY HOME HEALTH
PO Box 206
Astoria, OR 97103
503/325-8500

CONTACT PERSON: Lois Dodson
AREA: Clatsop County
SERVICES: Nursing, Home Health Aide, Physical Therapy, Speech Therapy, Occupational Therapy, Clerical, Medical Supplies, Durable Medical Equipment

COMMUNITY HOME CARE, INC.
1015 N. Riverside
Medford, OR 97501
503/779-5033

CONTACT PERSON: Peg Crowley
AREA: Jackson & Josephine Counties
SERVICES: Nursing, Home Health Aide, Personal Care Aide, Physical Therapy, Speech Therapy, Occupational Therapy, Medical Social Service, Hospice, Clerical, Medical Supplies, Durable Medical Equipment, Homemaker, Accounting

This information current as of 10/1/86

DESCHUTES HOME HEALTH CARE
2502 NE Neff Road
Bend, OR 97701
503/388-7796

CONTACT PERSON: Helen Durant
AREA: Deschutes County
SERVICES: Nursing, Home Health Aide, Physical Therapy, Speech Therapy, Occupational Therapy, Medical Social Service, Hospice, Medical Supplies

GOOD SAMARITAN HOME HEALTH
2282 NW Northrup, 2nd Floor
Portland, OR 97210
503/229-7485

CONTACT PERSON: Paulette Olson
AREA: Multnomah County
SERVICES: Nursing, Home Health Aide, Physical Therapy, Speech Therapy, Occupational Therapy, Medical Social Service, Nutritionist

HOSPITAL BASED HOME CARE PROGRAM
Portland Veterans Administration Medical Center
3710 S.W. U.S. Veterans Hospital Road
P.O. Box 1034
Portland, OR 97207
503/222-2873; 503/222-9221 Ext. 2472

CONTACT PERSON: Community Health Coordinators
AREA: 20 mile radius
SERVICES: Nursing, Medical Social Service, Dietetics, Patient's primary medical care must be provided by physicians at VAMC

MERCY MEDICAL CENTER
2700 Stewart Parkway
Roseburg, OR 97470
503/440-2384

CONTACT PERSON: Andrew C. Kyler
AREA: Douglas County, except Reedsport
SERVICES: Nursing, Home Health Aide, Physical Therapy, Speech Therapy, Occupational Therapy, Medical Social Service, Hospice, Clerical, Medical Supplies, Durable Medical Equipment, Respite. Hospice program provides 24-hour on call nursing, volunteer support, pastoral care and social service support for both patient and family

This information current as of 10/1/86

NU-CARE HOME HEALTH AGENCY
550 SE Clay
Dallas, OR 97338
503/623-8301

CONTACT PERSON: Becky Pape, Penny Crislip
AREA: 30 mile radius
SERVICES: Nursing, Home Health Aide, Physical Therapy, Speech Therapy, Occupational Therapy, Medical Social Service, Nutrition

OREGON ASSOCIATION FOR HOME CARE
1511 State Street
Salem, OR 97302
P.O. Box 510
Salem, OR 97308
503/399-7517

PORTLAND ADVENTIST HOME HEALTH
6040 SE Belmont
Portland, OR 97215
503/251-6301

CONTACT PERSON: Dorothy Rouse
AREA: 30 mile radius in Oregon
SERVICES: Nursing, Home Health Aide, Physical Therapy, Speech Therapy, Occupational Therapy, Medical Social Service, Clerical, Medical Supplies

PROVIDENCE MEDICAL CENTER
Home Health and Hospice
4805 NE Glisan
Portland, OR 97213
503/230-6175

CONTACT PERSON: Beverly Bruender, Kathy Landstrom
AREA: Multnomah, Clackamas and Washington Counties
SERVICES: Nursing, Home Health Aide, Physical Therapy, Speech Therapy, Occupational Therapy, Medical Social Service and Hospice Services

This information current as of 10/1/86

SACRED HEART HOSPITAL HOME HEALTH SERVICES
675 W. Broadway
Eugene, OR 97402
503/686-6442

CONTACT PERSON: Dixie Cole, Anna May Herbert
AREA: Lane County (except Western Lane Hospital Dist.)
SERVICES: Nursing, Home Health Aide, Physical Therapy, Speech Therapy, Occupational Therapy, Medical Social Service, Hospice, Clerical, Medical Supplies

ST. VINCENT HOSPITAL HOME CARE DEPT.
9205 SW Barnes Road
Portland, OR 97225
503/299-2001

CONTACT PERSON: Gelene Steudler, Karen Burdett
AREA: 30 mile radius
SERVICES: Nursing, Certified Nursing Assistant, Home Health Aide, Personal Care Aide, Physical Therapy, Speech Therapy, Occupational Therapy, Medical Social Service, Respiratory Therapy, Nutrition, Hospice, Clerical, Medical Supplies, Durable Medical Equipment, Homemaker

TILLAMOOK HOME HEALTH AGENCY
980 3rd St., #400
Tillamook, OR 97141
503/842-2588

CONTACT PERSON: Mike Kelly, Dorothy Rouse
AREA: Tillamook County
SERVICES: Nursing, Home Health Aide, Personal Care Aide, Physical Therapy, Speech Therapy, Medical Social Service, Clerical, Medical Supplies, Homemaker, Housekeeper, Companion, Live-in, Chore Service, Respite

This information current as of 10/1/86

V.N.A. HEALTH RESOURCES
P.O. Box 3426
Portland, OR 97208
503/220-1000

CONTACT PERSON: Winetta Soderlind, Jim Elmslie
AREA: Multnomah, Clackamas & Washington Counties
SERVICES: Nursing, Certified Nursing Assistant, Home Health Aide, Physical Therapy, Speech Therapy, Occupational Therapy, Medical Social Service Respiratory Therapy, Nutrition, Hospice, Clerical, Counseling, Homemaker, Home Care Specialist, Housekeeper, Companion, Live-in, Chore Service, Respite, Accounting, Pediatric Home Care, Private Duty Nursing, I V, Evenings, Enterostomal Therapy, Pediatric Rehabilitation, Home Phototherapy

WASHINGTON COUNTY HOME HEALTH CARE ASSN., INC.
1809 Maple Street
Forest Grove, OR
503/640-2737

CONTACT PERSON: LaVerne Kludsikofsky, William E. Winter
AREA: 30 mile radius of Hillsboro
SERVICES: Nursing, Home Health Aide, Physical Therapy, Speech Therapy, Occupational Therapy, Medical Social Service, Respiratory Therapy, Nutrition, Hospice, Clerical, Medical Supplies, Durable Medical Equipment, Accounting

WEST HOME CARE SERVICES
2865 Daggett St.
Klamath Falls, OR 97601
503/883-6293

CONTACT PERSON: Linda Beck, Marge Galloway
AREA: 30 mile radius
SERVICES: Nursing, Home Health Aide, Physical Therapy, Speech Therapy, Occupational Therapy, Medical Social Service, Respiratory Therapy, Nutrition, Hospice, Clerical, Medical Supplies

This information current as of 10/1/86

HEALTH CARE PROFESSIONAL ASSOCIATIONS

OREGON MEDICAL ASSOCIATION
510 S.S. Corbett
Portland, OR 97201
503/226-1555

OREGON NURSES ASSOCIATION (Statewide)
State Headquarters
9700 S.W. Capitol Highway
Portland, Oregon 97219
503/293-0011

This information current as of 10/1/86.

1/2/87

A BILL FOR AN ACT

Relating to public health; creating new provisions; amending ORS 433.001, 433.035, 433.106, 433.130, 433.216, 433.220 and 433.990; and repealing ORS 433.003, 434.005, 434.020, 434.050, 434.055, 434.070, 434.080, 434.090, 434.100, 434.130, 434.140, 434.160, 434.170, 434.180, 434.190, 434.200, 434.210, 434.250, 434.260, 434.270 and 434.990.

Be It Enacted by the People of the State of Oregon:

SECTION 1. ORS 433.001 is amended to read:

433.001. As used in ORS 433.001 to 433.770 unless the context requires otherwise:

(1) "Assistant director" means the Assistant Director for Health or authorized representative.

(2) "Communicable disease" means a disease or condition, the infectious agent of which may be transmitted from one person or an animal to another person, either by direct contact or through an intermediate host, vector or inanimate object, and that may result in illness, death or severe disability.

(3) "Division" means the Health Division of the Department of Human Resources.

(4) "Local Public Health Administrator" means the local public health administrator of the county or district under ORS 431.418 or authorized representative.

(5) "Public health measure" means isolation, quarantine or other preventative public health measure imposed on persons or property in order to prevent the spread of or exposure to diseases or contaminants of threat to the public.

(6) "Property" means animals, inanimate objects, vessels, public convenyances, buildings, and all other real or personal property.

(7) "Reportable disease" means a disease or condition, the reporting of which enables a public health agency to take action to protect or to benefit the public health.

(8) "Toxic substance" means a substance that may cause illness, disability or death to persons who are exposed to it.

SECTION 2. Sections 3, 4, 5, 7, 8, 10 and 11 are added to and made a part of ORS 433.001 to 433.106.

SECTION 3. (1) The division shall by rule:

(a) Specify reportable diseases;

(b) Identify those categories of persons who must report reportable diseases and the circumstances under which the reports must be made.

(c) Prescribe the procedures and forms for making such reports and for the transmission of the reports to the division.

(d) Prescribe measures for investigating the source of and for the control of reportable diseases.

(2) Persons required under the rules to report reportable diseases shall do so by reporting to the local public health administrator. The local public health administrator shall transmit such reports to the division.

(3) In addition to other grounds for which a state agency may exercise disciplinary action against its licensees or certificate holders, the substantial or repeated failure of such

a licensee or certificate holder to report under subsection (2) of this section when required by division rule to do so, shall be cause for the exercise of any of such agency's disciplinary powers.

SECTION 4. In response to each report of a reportable disease, the local public health administrator shall assure that investigations and control measures, as prescribed by division rule, shall be conducted.

SECTION 5. (1) Notwithstanding ORS 192.410 to ORS 192.500, the division, the local public health administrator, all officers and employes thereof and all persons to whom disclosures are made under this subsection or subsection (2) of this section shall not disclose the name or address of, or otherwise disclose the identity of, any person reported under Section 3 of this act except to officers or employes of federal, state or local government public health agencies as may be necessary for the administration or enforce-ment of public health laws or rules.

(2) If the division or local public health administrator has determined that a reported person's disease or condition is in a contagious state and that person is violating the rules of the division, pertaining to control of that disease, it may disclose that person's name and address to persons other than those stated in subsection (1) of this section if clear and convincing evidence in the particular instance requires disclosure to avoid a clear and immediate danger to other individuals or to the public generally. A decision not to disclose information under this subsection shall not subject the entity or person withholding the information to any liability.

3 - A BILL FOR AN ACT

(3) Except where required in connection with the administration or enforcement of public health laws or rules, no public health official or employe shall be examined in an administrative or judicial proceeding as to the existence or contents of a report under Section 3 of this act or any record thereof.

(4) The disclosures and examination prohibited by this section may otherwise be authorized by the specific written consent of the person who is the subject of the report or of his authorized representative.

SECTION 6. ORS 433.035 is amended to read:

433.035. (1) Whenever the assistant director or any local public health [officer] administrator [receives a report that any person within the jurisdiction of the health officer is or is] reasonably [believed] believes any person to be [infected] afflicted with any communicable disease identified by rule of the division to be a reportable disease [may, if the assistant director or local health officer has reason to believe the report], he or she may cause a medical examination to be made of such person to determine whether the person is in fact [infected] afflicted with a communicable disease. The person who orders an examination pursuant to this section shall [prepare and submit to the division] in the order, make written findings stating the communicable disease that [the person ordering the examination] he or she believes the person to be [infected] afflicted with, the reasons for that belief, that medical or laboratory confirmation of the disease is feasible, possible and that such confirmation would enable control measures to be taken to minimize

infection of others with the disease. The order shall also include a statement that the person may refuse to submit to the examination and that if so, a public health measure may be imposed.

(2) When any person is directed to submit to an examination under subsection (1) of this section, if the person agrees to do so, the person shall submit to such examination as may be necessary to establish the presence or absence of the communicable disease for which the medical examination was directed. The examination shall be carried out by the local health officer or a physician licensed by the Board of Medical Examiners for the State of Oregon or the Naturopathic Board of Examiners. A written report of the results of such examination shall be made to the [local health officers and the assistant director] person ordering the examination. Laboratory examinations, if any, shall be carried out by the laboratory of the division whenever such examinations are within the scope of the tests conducted by the laboratory. If treatment is needed, the person, the parent or guardian of the person shall be liable for the costs of treatment based on the examination carried out under this section, when able to pay such costs. Cost of any examination performed by a physician in private practice shall be paid from public funds available to the local public health [officer] administrator, if any, or from county funds available for general governmental expenses in the county for which the local public health [officer] administrator serves or in the county where the person examined resides if the local public health [officer] administrator serves more than one county or the examination was

or the examination was ordered by the assistant director.

(3) [Any] If the person directed to submit to a medical examination pursuant to subsection (1) of this section [who] refuses to do so [may be quarantined by order of] the assistant director or the local health [officer] administrator may impose a public health measure pursuant to ORS 433.106 and sections 10 and 11 of this 1987 act. [for such a period and subject to such conditions as the assistant director specifies in the order].

(4)[(a) Any person described in subsection (3) of this section or the agent of the person may petition a circuit court for an order of release from quarantine. The court shall hold a hearing within 48 hours from the date of filing of the petition and, if satisfied that there is no reasonable cause to believe that the person has a communicable disease, shall order that the person be released from quarantine.

(b) The court may, in its discretion, order that the person be brought before the courts.] In any proceeding under ORS 433.106, section 10 and section 11 of this 1987 act, the lack of confirming medical or laboratory evidence that could be obtained by an examination which was refused when requested under this section, shall not preclude a finding that probable cause exists.

[(5) As used in this section, "communicable disease" means a disease that may be transmitted from one person or an animal to another person, either by direct contact or through an intermediate host, vector or inanimate object, and that may result in illness, death or severe disability.]

6 - A BILL FOR AN ACT

SECTION 7. The division shall provide the necessary laboratory examinations requested by local health departments for the diagnosis of those communicable diseases identified by rule of the division to be a reportable disease.

SECTION 8. (1) Every licensed physician attending a pregnant woman in this state for conditions relating to her pregnancy during the period of gestation or at the time of delivery, in the case of every woman so attended, shall take or cause to be taken a sample of blood of such woman at the time of the first professional visit, or within 10 days thereafter. The blood specimen thus obtained shall be submitted to a licensed laboratory for such tests related to any infectious condition which may affect a pregnant woman or fetus, as the division shall by rule require.

(2) Every other person permitted by law to attend a pregnant woman in this state, but not permitted by law to take blood samples, shall cause a sample of blood of such pregnant woman to be taken by a licensed physician, and have such sample submitted to a license laboratory for the tests described under subsection (1) of this section.

(3) In all cases under subsection (1) and (2) of this section the physician shall request consent of the patient to take a blood sample. No sample shall be taken without such consent.

SECTION 9. ORS 433.106 is amended to read:

433.106. (1) The assistant director or any local[, county or district health officer] public health administrator may in the

7 - A BILL FOR AN ACT

manner described in sections 10 and 11 of this 1987 act impose public health measures on [shall have the power to isolate or quarantine] people, animals, inanimate objects, vessels and public conveyances, [or institute other preventive [medical] public health measures,] in order to prevent the spread of or exposure to [communicable] diseases or contaminants of threat to the public [community and shall post such notices of isolation or quarantine as the division may by rule require. Such isolation or quarantine shall be in accordance with rules adopted by the division].

SECTION 10.

(1) As used in this section "subject of the petition" means the person or the property upon which the public health measure is sought to be imposed.

(2) Except as provided in section 11 of this 1987 Act, proceedings for imposing a public health measure shall be initiated by filing a petition in the circuit court for the county in which the subject of the petition is located. If the property which is the subject of the petition is in more than one county, then the petition may be filed in the circuit court for any one of those counties. The petition shall name as the respondent, the person who is the subject of the petition or the person who possesses the property which is the subject of the petition, shall describe the public health measure requested and shall allege:

(a)(1) The subject of the petition is afflicted with or contaminated with, or contains persons or property afflicted or contaminated with an infectious agent of a communicable disease designated a reportable disease by the division; or

(a)(2) The subject of the petition is contaminated with or contains property contaminated with a toxic substance; and

(b) The subject of the person poses a substantial threat to public health; and

(c) The responsent is unable or unwilling to behave or to control the subject of the petition so as not to expose other persons to danger of infection or contamination; and

(d) The public health measure requested is necessary and the least restrictive alternative measure under the circumstances to protect or preserve the public health.

The petition shall be accompanied by an affidavit or affidavits based upon the investigation of the assistant director or the local public health administrator supporting the allegations in the petition.

(3) If the court, upon the basis of the affidavits, concludes that there is probable cause for the allegations in the petition, it shall, by issuance of a citation as provided in subsection (11) of this section, cause the respondent to be brought before it at a time and place as it may direct, for a hearing on the petition. The court shall also issue a warrant of detention to the sheriff of the county or counties, directing the sheriff or the sheriff's designee to place the subject of the petition under custody and where the subject of the petition is a person, to produce the subject at the time and place stated in the warrant.

(4) At the time the subject of the petition is placed under custody, the respondent shall be served certified copies of the warrant of detention, the citation and petition and informed by

the sheriff or designee of either the right to legal counsel, to have legal counsel appointed if the person is unable to afford legal counsel, and, if requested, to have legal counsel immediately appointed.

(5) A person placed under custody under subsection (4) of this section may as appropriate and as directed by the court be held in a residence or in a health care or other facility consistent with the requirements of subsection (19) of this section and receive the care, custody and treatment required for mental and physical health and safety. The treating physician shall report any care, custody and treatment to the court as required in subsection (9) of this section. All methods of treatment, including the prescription and administration of drugs, shall be the sole responsibility of the treating physician. Property placed under custody shall be detained as described by the court either under the possession of the respondent or under the possession of the sheriff, or the sheriff's designee. Property detained under the possession of the sheriff will be provided care and treatment which is reasonable under the circumstances.

(6) The hearing may be held in the place where the subject of the petition is being held in custody or in some other place convenient to the court and the respondent. The hearing shall be held within three judicial days of the commencement of detention. The court may for good cause, allow the person or property to be detained up to an additional 72 hours if additional time is requested by the respondent or the legal counsel of the respondent.

The court may make any orders for the care and custody of the subject of the petition as it deems necessary.

(7) The petitioner shall prepare or cause to be prepared an investigative report setting forth the evidence on which the evidence is based. A copy of the investigation report shall be provided as soon as possible, but in no event later than 24 hours prior to the hearing, to the respondent and to the respondent's counsel. Copies shall likewise be provided to counsel assisting the court, to the examiners and to the court for the use in questioning witnesses.

(8) The provisions of ORS 40.230, 40.235, and 40.240 shall not apply in a hearing under this section insofar as the information is relevant to the proceeding. Such evidence shall be disclosed only to the court, the examiners, the parties and their attorneys or persons authorized by the court and shall not be disclosed to the public.

(9) The court shall be fully advised by the treating physician of all drugs and other treatment known to have been administered to the subject of the petition, which may be pertinent to the subject's infectious or contaminated state. The medical record of treatment shall be made available in order that the examiners may review the medical record of treatment and have an opportunity to inquire of the medical personnel concerning the treatment of the respondent during the detention period prior to the hearing. Such record shall be made available to counsel for said respondent at least 24 hours prior to the hearing.

11 - A BILL FOR AN ACT

(10) The person serving a warrant of detention, citation and petition provided for by subsection (11) of this section shall, immediately after service thereof, make a return showing the time, place and manner of such service and file it with the clerk of the court. In executing the warrant of detention, the person has all the powers provided by ORS 133.235 and 161.235 to 161.245 and may require the assistance of any peace officer or other person.

(11) The citation issued to the respondent shall state the nature of the proceedings and the public health measure requested in the petition. The citation shall further contain a notice of the time and place of the hearing, the right to legal counsel, the right to have legal counsel appointed if the respondent is unable to afford legal counsel, and, if requested, to have legal counsel immediately appointed, the right to subpena witnesses in behalf of the respondent to the hearing and other information as the court may direct. The citation shall be served upon the respondent by delivering a certified copy of the original thereof to the person in person prior to the hearing. The respondent shall have an opportunity to consult with legal counsel prior to being brought before the court.

(12) The respondent shall have the right to cross-examine all witnesses, the person conducting the investigation, the examining physicians or other qualified persons who have examined the subject of the petition.

(13) At the time the respondent appears before the court, the court shall advise the respondent of the nature of the pro-

ceedings and the possible results of the proceedings. The court shall also advise respondent of the right to subpena witnesses and to obtain suitable legal counsel possessing skills and experience commensurate with the nature of the allegations and complexity of the case during the proceedings, and that if the respondent does not have funds with which to retain legal counsel, the court will appoint legal counsel to represent the respondent without cost. If the respondent does not request legal counsel, the legal guardian, relative or friend may request the assistance of suitable legal counsel on behalf of the respondent.

(a) If no request for legal counsel is made, the court shall appoint suitable legal counsel unless counsel is expressly, knowingly and intelligently refused by the respondent.

(b) If the respondent is unable to afford legal counsel, the court shall determine and allow, as provided in ORS 135.055, the reasonable expenses of the person and compensation for legal counsel. The expenses and compensation so allowed by a county court shall be paid by the county. In all cases suitable legal counsel shall be present at the hearing and examination and may examine all witnesses offering testimony, and otherwise represent the respondent.

(c) The governing body of the county shall designate either the district attorney or counsel appointed pursuant to ORS 203.145 to assist the court in the conduct of the hearing if the court requests assistance. If the person so designated has a conflict

of interest in a particular case, the court may appoint private counsel to render such assistance.

(d) If the respondent, the legal counsel or guardian, or examiners request, the court may, for good cause, postpone the hearing for not more than 72 hours in order to allow preparation for the hearing. The court may make orders for the care and custody of the subject of the petition during a postponement as it deems necessary.

(14)(a) In the case where it is alleged that the subject of the petition is afflicted with an infectious agent of a communicable disease, the court shall appoint at least one competent physician licensed by the State Board of Medical Examiners for the State of Oregon and expert in the field of infectious diseases or public health to examine the respondent as to the matters alleged in the petition. The person appointed may be the county health officer or other person recommended by the local public health administrator.

(b) In the case where it is alleged that the subject of the petition is contaminated with a toxic substance, the court shall appoint an expert on the particular subject, who may be the county health officer of other person recommended by the public health administrator, to examine the subject of the petition as to the matters alleged in the petition.

(c) If the respondent requests in writing that one additional examining physician or qualified person be appointed, or, in the absence of such request by the respondent, if such request

is made by the legal guardian, relative or friend of the respondent, the court shall appoint an additional physician or other qualified person.

(15) The persons appointed to conduct the examination shall make their separate report in writing, under oath, to the court. The reports shall be filed immediately with the clerk of the court. If the examining persons find, and show by their reports, that the allegations described in subsection (2)(a) through (c) of this section are true, the reports shall include a recommendation as to whether the allegations described under subsection (2)(d) of this section are true or as to alternative measures that would satisfy subsection (2)(d) of this section.

(16) After hearing all of the evidence and reviewing the findings of the examining persons, the court shall determine the truth of the allegations contained in the petition and the need for the requested public health measure. If, based upon clear and convincing evidence, it is the opinion of the court that the allegations are true, the court shall order the requested order or may order such other measure as from the evidence and recommendations the court deems appropriate to satisfy subsection (2)(d) of this section.

(17) The order shall be for a period of time not to exceed 60 days.

(18) If a respondent appeals the determination or disposition based thereon, and is unable to afford suitable legal counsel possessing skills and experience communsurate with the nature

and complexity of the case to represent the respondent on appeal, the court, upon request of the respondent or upon its own motion, shall appoint suitable legal counsel to represent the respondent. The compensation for legal counsel and costs and expenses necessary to the appeal shall be determined and allowed by the appellate court as provided in ORS 138.500 . The compensation, costs and expenses so allowed shall be paid as provided in ORS 138.500.

(19)(a) No person, not incarcerated upon a criminal charge, who is the subject of a petition under this section shall be confined in any prison, jail or other inclosure where those charged with a crime or a violation of a municipal ordinance are incarcerated, unless the person represents an immediate and serious danger to staff or physical facilities of a hospital or other facility to which committed.

(b) No respondent the subject of a petition and who has been taken into custody shall be confined, either before or after the hearing, without an attendant in direct charge of the person; and if not confined in a health care facility, the sheriff having the person in custody shall select some suitable person to act as attendant in quarters suitable for the comfortable, safe and humane confinement of the person and approved by the assistant administrator or local public health administrator.

(20)(a) Upon receipt of the order of the court, the sheriff or the sheriff's designee shall take the subject of the petition

into custody, and insure the safekeeping and proper care of the subject until delivery is made to an assigned facility or other location. During custody of the subject, the sheriff or sheriff's designee or the representative of the facility has all the powers provided by ORS 133.225 and 161.255 and may require the assistance of any peace officer or other person.

(b) The court may authorize the guardian, custodian, friend or relative to transport the subject of the petition to the designated facility or location when the court determines that the means of transportation would not be detrimental to the welfare of the subject or to the public.

(21) The judge shall cause to be recorded and filed in the court records a full account of proceedings had at all hearings and examinations conducted pursuant to this section together with the judgments and orders of the court and a copy of the orders issued. If the respondent is the subject of the petition, the court clerk shall seal the record and it shall not be disclosed to any person except:

(1) To the assistant administrator or local public health administrator;

(2) As provided in subsection (22) of this section:

(3) Upon request of the respondent, the legal representatives, or the attorney of the person; or

(4) Pursuant to court order.

(22) If the subject of the petition is ordered committed to a facility, a copy of the judgment and orders of the court, medical records and such other information as the court deems

necessary, certified to by the court clerk shall be given to the sheriff, for delivery to the director of the facility to which such person is committed.

(23) The assistant director or local public health administrator shall, by filing a written certificate with the ordering court, discharge the subject of the petition except where the subject is being held upon an order of a court or judge having criminal jurisidiction in an action or proceeding arising out of a criminal offense, when in the local public health administrator's opinion the matters alleged in the petition are no longer true.

(24)(a) At the end of the 60-day period the subject of the petition shall be released from the order unless the assistant director or the local public health administrator certifies to the ordering court that the order should be continued. If the certification is made the subject shall not be released from the order but the assistant director or local public health administrator shall immediately issue a copy of the certification to the respondent.

(b) The certification shall be served upon the respondent by the sheriff or the sheriff's designee. The sheriff shall inform the court in writing that service has been made and the date thereof.

(c) The certification shall advise the respondent:

(i) That the assistant director or local public health administrator has requested that the order be continued for an additional period of time;

(ii) That the respondent may consult with legal counsel and that legal counsel will be provided for the respondent cost if the respondent is unable to afford legal counsel;

(iii) That the respondent may protest this further extension of the order within 14 days, and if the respondent does not it will be continued for an indefinite period of time up to 180 days;

(iv) That if the respondent does protest a further extension of the order, the respondent is entitled to a hearing before the court on whether it should be continued;

(v) That the respondent may protest either orally or in writing by signing the form accompanying the certification; that the respondent is entitled to have a physician or other qualified person examine the subject of the petition and report to the court the results of the examination;

(vi) That the respondent may subpena witnesses and offer evidence on behalf of the respondent at the hearing; and

(vii) That if the respondent is without funds to retain legal counsel or an examining physician or qualified person, the court will appoint legal counsel, a physician or other qualified person at no cost to the respondent.

(d) The person serving the certification shall read and deliver the certification to the respondent and ask whether the respondent protests a further extension of the order. The respondent may protest a further extension either orally or by signing a simple protest form to be given to the respondent with the certification. If the respondent does not protest a further

extension of the order within 14 days of service of the certification, the assistant administrator or local public health administrator shall so notify the court and the court shall, without further hearing, order the extension of the order for an additional period of time up to 60 days.

(25) When the respondent protests a further extension of the order the assistant administrator or local public health administrator shall immediately notify the court and the court shall have the respondent brought before it and shall again advise the respondent that the assistant administrator or the local public health administrator has requested that the order be continued for an additional period of time and that if the respondent does not protest this it will be continued for an indefinite period of time up to 180 days. The respondent shall also be informed of the rights set forth in subsection (24) of this section.

(26) If the respondent requests a hearing, the hearing shall be conducted as promptly as possible and at a time and place as the court may direct. If the respondent requests a continuance in order to prepare for the hearing or to obtain legal counsel to represent the repsondent, the court may grant a continuance for up to 72 hours for this purpose. In the event the respondent requests the appointment of legal counsel and is without funds to retain legal counsel, the court shall appoint legal counsel to represent respondent at no cost to the respondent. If no request for legal counsel is made, the court shall appoint legal counsel to represent respondent unless legal counsel is expressly,

20 - A BILL FOR AN ACT

knowingly and intelligently refused by the respondent. If the respondent requests an examination by a physician or other qualified person and is without funds to retain a physician or other qualified person for purposes of the examination, the court shall appoint a physician or other qualified person, other than a member of the staff from the facility where the respondent may be confined, to examine the respondent at no expense to the respondent and to report to the court the results of the examination. The court shall then conduct a hearing and after hearing the evidence and reviewing the recommendations of the treating and examining physicians or other qualified person, the court shall determine whether the order should be continued. If in the opinion of the court the allegations of the original petition are still applicable to the subject of the petition by clear and convincing evidence the court may continue the order for an additional indefinite period of time up to 60 days or may order such other measure to satisfy subsection (2)(d) of this section. At the end of the 60-day period, the subject of the petition shall be released unless the assistant director or local public health administrator again certifies to the committing court that the order should be extended in which event the procedures set forth in subsections (24) through (26) of this section shall be followed. followed.

(26) Neither the assistant director or any local public health administrator, sheriff, peace officer, physician, attorney, judge or other person or entity shall in any way be held criminally or civilly liable for actions pursuant to this section

21 - A BILL FOR AN ACT

and section 11 of this 1987 Act provided the actions are taken in good faith, without malice and based on reasonable belief.

SECTION 11.

(1) Without the necessity of first filing a petition and affidavits under section 10 of this 1987 Act, if the assistant director or local public health administrator has probable cause to believe that the person or property to be the subject of a petition under section 10 requires immediate detention in order to avoid a clear and immediate danger to other individuals or to the public generally, the assistant director or local public health administrator may direct a sheriff or other peace officer to take such subject into custody and the peace officer shall do so immediately.

(2) A person or property taken into custody under this section shall be immediately removed to the nearest health care facility or other location consistent with the provisions of section 10, subsections (5) and (19) of this 1987 act.

(3) At the time of the peace officer taking custody of the person or property the peace officer shall inform the person in custody or the person who possesses the property of the directions under which the action is being taken and the right of the person to have legal counsel, and if requested, to have legal counsel immediately appointed.

(4) The assistant administrator or the local public health administrator after authorizing the taking of a person or property into custody under this section, shall immediately notify a circuit court in the county in which the person or property was taken into custody of the fact of taking the person into custody

and the person's or property's whereabouts. When the judge of such a court is informed the judge shall immediately hear evidence on the matter, determine whether probable cause exists for the detainment and enter an order as deemed appropriate by the court pending the filing of a petition and affidavits under section 10 of this 1987 Act. The court shall not allow the person or property to be held in custody for longer than five judicial days without a hearing under section 10 of this 1987 Act. The court may, for good cause, allow the person or property to be detained up to an additional 72 hours if additional time is requested by the respondent or the legal counsel of the respondent.

SECTION 12. ORS 433.130 is amended to read:

433.130. Any magistrate authorized to issue warrants in criminal cases shall issue a warrant upon affidavit of the assistant director or any local public health officer, directing the warrant to the sheriff of the county or the deputy of the sheriff, or to any constable or police officer, requiring them under the direction of the division to [remove any person who is infected with a communicable disease, or to impress or take up convenient houses, lodging, nurses, attendants and other necessaries, or to] enforce all quarantine, [or] isolation or other measures required by [rules of the division] orders under ORS 433.106, section 10 and section 11 of this 1987 Act.

SECTION 13. ORS 433.216 is amended to read:

433.216. If the assistant director finds that there is an imminent risk of the introduction into the state by means of any

public or private conveyance of any dangerous communicable disease or toxic substance which presents a substantial threat to public health [into the state by means of any public or private conveyance], the assistant director may detain such conveyance for inspection or investigation.

SECTION 14. ORS 433.220 is amended to read:

433.220. (1) If upon inspection pursuant to ORS 433.216, there is discovered among passengers or goods therein the existence of any [case of dangerous] communicable disease or toxic substance which presents a substantial threat to public health the assistant director, under the rules of the division may:

(a) Isolate or quarantine or impose other public health measures on such persons or goods in accordance with ORS 433.106, section 10 and section 11 of this 1987 Act.

(b) Cause the passengers and material in the involved conveyance to be subjected to requirements by the division for the control of the specific communicable disease or prevention of harm to the public health from the toxic substance.

(c) Offer free immunization in those diseases to which such prophylactic treatment is applicable to all persons exposed in any conveyance.

(2) Should any question arise as to the existence of any emergency the assistant director shall have final jurisdiction.

SECTION 15. ORS 433.990 is amended to read:

(1) Violation of Sections 3 and 5 of this 1987 Act, 433.106 to 433.156, 433.216, 433.220, 433.255, 433.260 or 433.715 is a Class A misdemeanor.

(2) Violation of ORS 433.010 is punishable, upon conviction, by imprisonment in the penitentiary for not more than three years.

(3) Violation of ORS 433.710 is punishable, upon conviction, by a fine of not less than $5 nor more than $50. If the nuisance is not removed within five days after the first offense, it is considered a second offense and every like neglect of each succeeding five days thereafter is considered an aditional offense.

(4) Violation of ORS 433.850(2) or (4) is a violation punishable by a fine or fines totaling not more than $100, in any 30-day period.

(5) Violation of ORS 433.345 or 433.365 or failure to obey any lawful order of the director issuedunder ORS 433.350 is a misdemeanor.

(6) Any organizer, as defined in ORS 433.735, violating ORS 433.745 is punishable, upon conviction, by a fine of not more than $10,000.

SECTIC 16. ORS 433.003, 434.005, 434.020, 434.050, 434.055, 434.070, 434.080, 434.090, 434.100, 434.130, 434.140, 434.160, 434.170, 434.180, 434.190, 434.200, 434.210, 434.250, 434.260, 434.270 and 434.990 are repealed.

25 - A BILL FOR AN ACT

AIDS BUDGET

Costs Incurred by Reportability of HIV

ASSUMPTIONS:

1. HIV positivity among those tested:
   15% 1987-88
   18% 1988-89

2. Number of tests performed:
   417 tests/mo. public sector
   300 tests/mo. private sector

3. 10% of private sector cases will be lost to follow-up after physician contact

4. Only "unaware" contacts (those likely to consider themselves at risk of HIV exposure) will be traced
   (a) 60% of positives - no "unaware" contacts
   (b) 30% of positives - one "unaware" contact
   (c) 10% of positives - five "unaware" contacts

5. STD investigator time estimates (at $13.24/hr.)
   (a) physician interview - 1 hour
   (b) patient interview (private sector) - 3 hours
   (c) patient interview (public sector) - 1 hour
   (d) contact notification - 3 hours

6. Other costs
   (a) counseling of contacts - $34.00 each
   (b) testing of contacts - $10.00 each

AIDS BUDGET
Costs Incurred by Reportability of HIV (Cont'd)

DURING THE 87-89 BIENNIUM:

In the private sector:
7200 persons tested
1188 HIV positive
1069 contacted and interviewed
856 "unaware" contacts identified

HOURS (1188 + 3207 + 2568) = 6963

In the public sector:
10000 persons tested
1650 HIV positive
1650 interviewed
1320 "unaware" contacts identified

HOURS (1650 + 3960) = 5610*

TOTAL STD CONTACT NOTIFICATION TIME = 12,573 hours

BUDGET FOR STD INVESTIGATION TIME = $166,466

ADDITIONAL COSTS INCURRED
(Estimate 20 percent or 435 of 2,176 unaware contacts would be served under majority report. See Contact Notification Recommendations 2, 4 & 5 for detail)

ITEM	NUMBER	TOTAL COST	INCREMENTAL AMOUNT OR NUMBER	COST
STD Contact Notification Time	(see above)	$166,466	80%	$133,173
Contact Counseling	2,176	73,984	1,741	$ 61,370
HIV tests @ $10.30	2,176	$ 22,413	1,741	$ 17,932
			TOTAL	$212,475

*Physician interview not necessary for patients initially tested in public sector.

Department of Human Resources

OREGON HEALTH DIVISION'S GUIDELINES FOR SCHOOLS WITH CHILDREN WHO HAVE HEPATITIS B VIRUS OR HUMAN T-LYMPHOTROPIC VIRUS INFECTIONS

November, 1985

These guidelines were prepared as recommendations for school administrators developing policies and procedures for providing education in a safe manner to children infected with either the hepatitis B virus or the virus which causes AIDS (acquired immunodeficiency syndrome).

I. Background

A. General

Hepatitis B and AIDS are serious illnesses which are spread from one person to another primarily by sexual contact, and in certain circumstances, by blood contact. Hepatitis B virus infections are much more common in Oregon school children than AIDS virus infections. The risk of spread of either disease in the school setting is extremely low. Since the basic measures to reduce this low risk even further are similar for the two diseases, the guidelines for both are presented together.

B. Hepatitis B is a serious illness. Some infected persons develop no illness, but most older children and adults who are newly infected with the hepatitis B virus have a few weeks of illness and recover completely. Most of those who recover are infectious for a few weeks or months. About 5% to 10%, however, become chronic carriers of the hepatitis B virus. This carrier state may persist for a lifetime; it poses significant risk of serious chronic liver disease. About 40% of infants born to carrier mothers become carriers themselves.

A carrier may be infectious to others. The virus is not spread, however, by ordinary social contact. Instead, transmission occurs only when a body fluid such as blood, semen, or saliva from an infected person is introduced through *broken* skin or onto the mucous membranes of the eye, mouth, vagina or rectum. *The virus does not penetrate intact skin.* Specific methods of spread include sexual contact, sharing needles, exposure of cut or scratched skin to blood from a carrier, splash of blood into the mouth or eye, and biting by a carrier.

Carriers are not frequent in the general school age population, but children from certain groups are at somewhat increased risk of being carriers. These include children of Southeast Asian refugees, handicapped children who have lived in a large institution for the mentally retarded, and the children of intravenous drug abusing parents.

No significant risk of hepatitis B transmission has been documented in the school setting. The risk of transmission there, if any, is limited to students exposed to others exhibiting aggressive behaviors, such as biting or scratching, and to persons providing first aid to carriers with bleeding injuries.

An effective vaccine is available to protect against hepatitis B infection. This hepatitis B vaccine is given in three doses over a six month period. The three dose series costs over $100, plus charges for administering it. It is a safe vaccine: a sore arm occurs frequently at the injection site, but more serious side effects have not been documented.

C. AIDS or human T-lymphotropic virus-III (HTLV-III) infection

The cause of AIDS is the human T-lymphotropic virus-III (HTLV-III). AIDS is a serious illness, which essentially always leads to death. Most people infected with HTLV-III, however, do not develop AIDS at least over the first five or six years after they become infected. Some develop a milder illness called AIDS-Related Complex, while the majority do not develop any illness at all.

Current evidence suggests that nearly all persons who become infected with HTLV-III will continue to carry the virus in their blood for the rest of their lives even if they do not develop AIDS.

As with the hepatitis B virus, HTLV-III is not spread from one person to another by casual social contact. Spread occurs only when a body fluid, such as blood or semen, is introduced through *broken* skin or onto the mucous membranes of the eye, mouth, vagina, or rectum. HTLV-III has been isolated from blood, semen, saliva, and tears of AIDS patients, but transmission by saliva and tears has not been documented. Specific methods of spread have included sexual contact, sharing of IV needles, and transfusion of contaminated blood or blood products.

Adults at increased risk of infection have included homosexual and bisexual males, IV drug abusers, persons transfused with contaminated blood or blood products, and sexual contacts of persons with AIDS or at-risk of AIDS.

Most infected children have acquired the virus from their infected mothers, either before or during birth. Some have been infected by contaminated blood or blood products.

Available evidence indicates that the casual person-to-person contact that occurs among schoolchildren poses no risk of HTLV-III transmission. No case of AIDS or other HTLV-III infection in the U.S. is known to have resulted from spread in the school or day care setting or from other casual person-to-person contact. Except for sexual partners, needle-sharing partners, and infants born to infected mothers, no family member of an AIDS case in the U.S. has been reported to have AIDS. Furthermore, six special studies of family members of HTLV-III infected persons have found no evidence of spread to any household contacts except for sexual partners, needle sharing partners, or infants born to infected mothers.

If any risk of spread in the school setting exists, it would be limited to situations where open skin lesions or mucous membranes would be exposed to blood from an infected person. One example is a teacher providing first aid for a bleeding injury and getting blood into an open sore on his or her own hand. Another example is an aggressive, neurologically handicapped, or pre-school aged child significantly exposing other children by biting or mouthing behaviors.

Some children with HTLV-III infections may be at increased risk of serious illness if exposed to certain infections such as chickenpox, measles, tuberculosis, herpes simplex, and cytomegalovirus.

D. Legal Issues

Among the legal issues to be considered in forming policies for the education of children with hepatitis B or HTLV-III infections are the confidentiality of the student's record, the employee's right-to-know, the responsibility of the school district to provide a safe and healthy environment for students, the civil rights aspects of public school attendance, and the protections for handicapped children.

E. Confidentiality Issues

School personnel, parents, and others involved in the education of children with hepatitis B or HTLV-III infections should be aware of the potential for social isolation should the child's condition become known to others. They should be sensitive to the need for confidentiality.

II. Recommendations

A. General

1. Intensive education about hepatitis B and HTLV-III infection should be provided, *as soon as possible,* to school personnel and the general public. This education should emphasize information about how the infections are spread and how they are not spread. It should be done *before* problems arise in individual schools. The Oregon Health Division, local health departments, Oregon Department of Education, Education Service Districts, and local school districts should cooperate to develop and deliver this education.
2. Because of the small risk of blood-borne hepatitis B transmission from carriers who are not known to be infected, and because most HTLV-III-infected children will not be identifiable, general precautions should be observed by first aid providers in *all* situations involving exposure to blood. These precautions apply to bleeding injuries of *all* children, not just those known or suspected to be infected:
   a. If you have cuts, scratches, or other lesions on your hands, wear disposable plastic gloves when providing first aid for bleeding injuries.
   b. You should wash your hands immediately after completing the first aid.
   c. Avoid getting blood from an injured child in your mouth or eyes. If such an exposure occurs, rinse the eye or mouth thoroughly with water.
   d. Clean up any spilled blood with soap and water, followed by disinfection with a freshly made solution of one part bleach to 10 parts water.
   e. Place blood-contaminated items such as gloves, bandages, and paper towels in a plastic bag, tie it closed, and put it in the garbage receptacle.
   f. Report the first aid situation to your supervisor.
3. The following precautions should be applied in classrooms, particularly those serving handicapped individuals. These include:
   a. A sink with soap, running water, and disposable towels should be available close to the classroom.
   b. Sharing of personal toilet articles, such as toothbrushes and razors, should not be permitted.
   c. Skin lesions which may ooze blood or serum should be kept covered with a dressing.
   d. Exchange of saliva by kissing on the mouth, by sharing items which have been mouthed, and by putting fingers in others' mouths should be discouraged.
   e. Environmental surfaces which may be regularly contaminated by students' saliva or other body fluids should be washed daily with soap and water.

B. Hepatitis B—Specific Recommendations

1. Attempts to specifically identify carrier children are generally discouraged. The exceptions to this are the previously institutionalized, handicapped individuals who are subject to frequent injuries, who have frequent visible bleeding from the gums, or who have aggressive or self-destructive behaviors (biting, scratching, etc.) that may lead to bleeding injuries. Such an individual should be screened for the hepatitis B carrier state. The hepatitis B surface antigen (HBsAg) blood test should be used. If the test is positive, see (2) below.
2. If a student is identified to be a hepatitis B carrier, the local health department should be consulted for individualized special precautions to be incorporated into the educational program for that child. Such precautions may include restricting contacts with other students and assuring that the teaching staff is immunized.
3. School staff members who provide direct personal care to previously institutionalized, handicapped students should be advised by the local school district of the availability of hepatitis B vaccine and encouraged to consult with their personal physician or local health department for information about it.
4. The parents or residential caretakers of handicapped students who are likely to have ongoing classroom or household contact with previously institutionalized, handicapped individuals should be advised of the availability of hepatitis B vaccine and encouraged to consult with their personal physician or health department for information about it.
5. *All* school staff members, including custodians, bus drivers, and secretaries should be fully informed of these recommendations as part of annual inservice training.

C. AIDS—Specific Recommendations

1. AIDS is a legally reportable disease. When a child under age 21 with AIDS is reported, the Health Division or county health department will immediately request the parent(s) or guardian(s), if they wish the child to continue to receive education, to notify the local school district superintendent. The local health officer or Division administrator will issue an order to exclude the child from school, until the school superintendent has been notified and an educational program has been planned for the child. In order to determine whether special measures are necessary for continuing the education of the child, the superintendent and health agency should convene a planning team, which should include the child's parent(s) or guardian(s), the child's physician, the school nurse, and representatives of the Division, the local health department, the local school district superintendent, and the Department of Education.

   For the preschool child receiving regular care outside the home, the team should include the child's parent(s) or guardian(s), the child's physician, Division and local health department representatives, and a representative of the care provider.
2. Decisions regarding the type of educational and care setting for children with AIDS should be based on the behavior, neurologic development, and physical condition of the child and the expected type of interaction with others in that setting.
3. In general, it is expected that HTLV-III infected school-aged children (K-12) will be able to attend school without restriction.
4. In general, it is expected that, until more is known about the degree of risk, HTLV-III infected children under the age of five years will face some restriction of contact with other children in school and day care settings.
5. For some neurologically handicapped children who lack control of their body secretions or who display behaviors, such as biting, and those children who have uncoverable, oozing lesions, a more restricted environment is advisable until more is known about transmission from such individuals. Such children infected with HTLV-III should be cared for and educated in settings that minimize exposure of other children to blood or body fluids.
6. Strict confidentiality should be maintained in accordance with state and federal laws and local school district policies. Knowledge of the child's condition should be shared with others only if the school superintendent determines it is necessary to do so after receiving recommendations from the team.
7. Care involving exposure to the infected child's body fluids and excrement, such as feeding and diaper changing, should be performed by persons who are aware of the child's AIDS status and the modes of possible transmission. In any setting involving a person with AIDS, good handwashing after exposure to blood and body fluids and before caring for another child should be observed, and gloves should be worn if open lesions are present on the caregiver's hands. Any open lesions on the infected person should be covered.
8. Reevaluation of the individual child's need for a restricted environment should be done regularly, as well as upon special request by the teacher or principal, for the hygiene practices of the child may improve or deteriorate.
9. All school staff members, including custodians, bus drivers, and secretaries, should be fully informed of these recommendations and basic hygiene practices as part of annual inservice training.

BUREAU OF LABOR AND INDUSTRIES
Mary Roberts, Commissioner

Mr. Barry Rice
Executive Director
Oregon Dental Association
17898 SW McEwan Rd.
Tigard, OR. 97223

November 18, 1986

Dear Mr. Rice,

On November 10 I read an Oregonian story titled "Precautions against AIDS stir questions" concerning additional fees charged by dentists to treat AIDS patients. While the story points out the obvious need of dentists and other health care professionals to protect themselves, their employees and other patients against the possible threat of AIDS contagion, it also detailed what could be a violation of the state's civil rights laws protecting handicapped individuals in the use of public accommodations.

ORS 659.405, and 659.425(4) state that it is the public policy of Oregon to guarantee physically and mentally handicapped persons the use and enjoyment of places of public accommodation. No place of public accommodation, which includes medical facilities in most cases, may discriminate against a customer or patron because of a mental or physical handicap, or because the individual is perceived as being handicapped. Discrimination is defined as unequal treatment in accommodations, advantages, facilities and privileges.

Oregon and 20 other states treat AIDS as a handicap for the purposes of the states' civil rights laws. In addition, those who have ARC or test seropositive for HIV in Oregon are covered by the same laws because they are perceived as being handicapped individuals. Therefore, they should be provided the same services as others, at the same fee. It would be illegal for a dental office to refuse treatment of an AIDS patient under the state civil rights law and rules that interpret that law, and may well be illegal to charge an additional fee for the same services for treatment of those patients. The same law that prohibits restaurants from charging more for a meal served to handicapped guests also protects AIDS victims who must seek dental care.

It is reasonable to expect that AIDS victims, and those who believe they may be at risk, will not inform the dentist of the situation if the consequences of that action result in a $95 charge not covered by medical insurance. Dentists and other dental health care professionals would then be treating these patients unknowingly by discouraging disclosure.

Though the U.S. Department of Health and Human Services has determined that normal operatory preparation and sterilization techniques may be insufficient to protect against the HIV virus and other infectious diseases, no AIDS cases have been linked to transmission through dental contact.

If AIDS or ARC victims, or those who test positive for HIV come to the Bureau of Labor and Industries to file a complaint alleging discrimination in public accommodation because of additional fees charged for medical or dental care, we will accept those claims, to determine if illegal discrimination has occurred.

Your members, your organization, as well as the ADA, are to be commended for addressing the precautions needed to prevent the spread of this disease. However, dentists should be made aware that the imposition of discriminatory fees as a result of those precautions may be a violation of civil rights laws.

Please contact my office if I can offer any further help on this issue.

Sincerely,

Mary "Wendy" Roberts

cc: Susan Graber
enclosures: Civil rights statutes and rules

MWR/kw

Department of Human Resources

OREGON HEALTH DIVISION'S GUIDELINES FOR AIDS IN THE WORKPLACE

September, 1986

Preamble: The risk of transmitting an infectious disease in any setting is determined by the specific ways in which the disease is spread, and the activities performed by persons in that setting. Generally, persons are at less risk of exposure to infectious diseases in the occupational setting than they are during the time spent outside work.

Infections of greatest concern in the workplace are those transmitted by the respiratory route (examples: measles, influenza). At a much lower level of risk, diseases spread by the fecal-oral route (examples: hepatitis A, salmonellosis), or by close personal contact (examples: staphylococcal skin infections, head lice) may be of concern. Good personal hygiene (handwashing, covering coughs and sneezes, etc.), early diagnosis and treatment, exclusion from work while infectious if a risk of transmission exists, and adequate environmental hygiene — are the primary defenses against the spread of infectious disease.

Blood-borne and sexually-transmitted infections (examples: hepatitis B and the AIDS virus, HIV) are generally of little concern in the workplace because they require mucous membrane or blood exposure to an infected person's blood or body fluids in order for transmission to occur. This usually means sexual contact or injectable drug and needle sharing with the person who is ill. However, given concerns about the acquired immunodeficiency syndrome (AIDS), the Oregon Health Division is issuing the following set of guidelines.

A. Background.

1. The causative agent of AIDS is a virus, known as human immunodeficiency virus (HIV). It is also known as the human T-lymphotropic virus type III (HTLV-III).
2. The HIV is most commonly transmitted through intimate sexual contact involving exchange of semen and/or other body fluids, or via sharing of infectious blood during i.v. drug abuse. Newborn infants may be infected perinatally by infected mothers.
3. The vast majority of persons infected with this virus are currently free of symptoms, and are unaware that they have been infected.
4. There is *no* evidence to date that casual contact exposure has led to transmission of the virus. There is much evidence from the study of household contacts of AIDS cases that spread of the infection does *not* occur through casual contact.
5. Many infected persons may never become ill from this infection; however, all persons infected with HIV must be presumed to be capable of transmitting the virus to others, through sexual contact or blood contact.
6. An infected person may experience a spectrum of clinical conditions, and may remain without symptoms indefinitely. It generally takes 3 years or more for an infected person to develop AIDS, among that small percentage of infected persons who develop the syndrome.
7. Once diagnosed as having AIDS, most patients die within 2 years.
8. The virus is quite fragile and is quickly killed on environmental surfaces, when treated with common, inexpensive disinfectants (see below).
9. At present, the only means available to ascertain a person's infection status is a special antibody test. If a person is infected, the test should become positive within 12 weeks. However, the test is not 100% accurate, and for many reasons is not recommended for routine screening of all persons.

B. Recommendations:

1. Each employer should adopt an infection control policy. Steps should be taken to insure that all employees understand and are following the policy. Each employee should receive written copies of the guidelines.

Infection control guidelines: [These apply to all situations, not just to those persons known to have AIDS, HTLV-III infection, or hepatitis B.]

a. All sharp objects which could be a source of cuts, punctures, or lacerations, should be covered where possible or labeled appropriately. When needles are used in health care facilities, personnel should be educated *not* to resheath them after use. Sharp objects must be disposed of in safe containers so as not to pose a hazard for custodial personnel. [Special procedures may be appropriate where moving machinery exists which could cause a bleeding injury, such as on assembly lines.]

b. Persons with cuts, scratches, or other lesions on the hands or other exposed areas, should wear covering bandages and/or gloves to prevent blood/body fluid contamination of their surroundings, of themselves, or of other persons.

c. Whenever possible, disposable rubber or plastic gloves should be worn when providing first aid for bleeding injuries. However, administration of appropriate care should not be delayed because gloves are not available.

d. Contact of the skin with blood or body fluids from other persons should be avoided. If such exposure occurs, the affected skin should be washed thoroughly with soap and water.

e. Contact with the mouth, eyes, or other mucous membrane areas with blood or other body fluids from other persons should be avoided. If such exposure occurs, the affected region should be washed thoroughly with water.

f. Environmental surfaces on which blood has been spilled should be cleaned promptly with soap and water, followed by disinfection with a freshly made solution of one part bleach to 10 parts water. Some commercially available disinfectants are an acceptable substitute.

g. Blood-contaminated items such as gloves, bandages, and paper towels should be placed in a sealed plastic bag, and immediately put in the garbage receptacle.

h. Hard, impervious containers should be used when disposing of sharp blood-contaminated materials which could cause injuries to others.

i. An incident in which blood from one person contacts mucous membranes or broken skin of another should be promptly reported to the supervisor.

C. Employer responsibility:

1. Each employer or work unit should provide:

a. An employee education program for all personnel, implemented as soon as possible. The education should emphasize information about the AIDS virus and how it is and is not spread. Each facility should have one person designated as responsible for implementing the education program, as well as for periodically updating the workforce with new facts about AIDS.

b. A source of water, soap, disinfectant solution, and disposable towels, close to the workplace.

c. First aid kits easily accessible to all employees. These should include disposable plastic gloves.

d. A written summary of infection control procedures to be followed, posted near first aid kits, restroom facilities, and rest areas.

D. Individual rights:

Each policy should be written in anticipation that an HIV-positive person will appear within the work force. AIDS is not a disease that will be transmitted in the workplace, if the infection control policy outlined above is implemented. Each policy should emphasize preservation of an individual's right to confidentiality, both in the interest of the employee's morale and to prevent hysteria and rumor, counterproductive to work efficiency.

E. Response plan:

1. Only a limited number of persons with a direct need to know should be informed of an infected person's medical condition, regardless of whether the infected person is an employee or has some other reason for being in the workplace (i.e. as a client, patient, etc.).

2. For employees, an effort should be made to treat the person's condition as any other major illness, including making reasonable accommodations so that the employee may continue to work as long as he/she is physically able to do so (when symptomatic). Documentation that such efforts at accommodation have been made should be recorded.

3. Contingency plans for dealing with disgruntled employees should be developed, giving such persons an opportunity to air concerns, and to receive further education about HIV infection and and the lack of risk of such infection in the occupational setting from this virus.

Additional comments:

A. HIV testing in the workplace is not recommended. Screening employees or applicants serves no purpose if the basic infection control precautions described above are followed. HIV antibody test results have no bearing on an individual's ability to work.

B. Hospitals and other health care settings may need to supplement these guidelines with more detailed advisories. In those specialized settings where an occupational exposure may have occurred (such as needlestick accidents in health care workers or first responders), a testing schedule should be arranged with the local county health department or the individual's personal physician.

C. HIV-related conditions should be treated as any other medical condition with respect to employee benefits.

D. Hiring/promotion criteria: According to interpretation of Oregon law by the Bureau of Labor and Industries, HIV seropositive persons, as well as patients with AIDS-related complex (ARC) and with AIDS, are viewed as physically handicapped (ref. 1). This principle has not been tested in the courts. If HIV positive persons are determined to be physically handicapped, this legal interpretation would preclude using HIV test results or a diagnosis of ARC or AIDS as the basis for employment termination or denial in many settings in Oregon.

A final note about benefits: companies that want to be farsighted in dealing with this epidemic may wish to consider case management programs within their benefits package, as a means to provide the best medical care at lowest cost. Case management programs were conceived to accommodate low incidence catastrophic illnesses with high cost of treatment. Hospice and home care are often proving to be the best form of care for persons with AIDS. Such case management programs should be an integral part of the overall health insurance package, rather than a strategy resorted to on an individual basis, to avoid inconsistencies (ref. 2).

The resources of the Oregon Health Division AIDS Program are available for assisting all employers in setting up employee education programs. Contact the Health Division in Portland at 229-5792 for more details.

Suggested for further reading:

1. Letter from Johnnie M. Bell, Administrator, Civil Rights Division, Bureau of Labor and Industries, State of Oregon, to James M. Campbell, Attorney at Law, dated March 13, 1986.
2. *AIDS: Employer Rights and Responsibilities*. Commerce Clearing House, Inc., 4025 W. Peterson Ave., Chicago, IL 60646, 1985, 95 pp.
3. Department of Human Resources, Oregon Health Division's Guidelines for Schools with Children who have Hepatitis B Virus or Human T-Lymphotropic Virus Infections. November, 1985.
4. Centers for Disease Control. Recommendations for preventing transmission of infection with human T-lymphotropic virus type III/lymphadenopathy-associated virus in the workplace. Morbidity and Mortality Weekly Report *34* (45): 681-686 (1985).

Additional copies of this advisory may be obtained from:

Oregon Health Division
AIDS Program, HSM
P.O. Box 231
Portland, OR 97207

THE OREGON HEALTH SCIENCES UNIVERSITY

School of Dentistry
Department of Pathology

611 Southwest Campus Drive Portland, Oregon 97201 (503) 225-8904

MEMORANDUM

TO: William S. TenPas, DMD, President
Oregon Dental Association

FROM: Murray H. Bartley, DMD MHB.

DATE: September 24, 1986

RE: DENTAL PROCEDURES AUTHORIZED FOR IMMEDIATE COMPENSATION FOR ADULT EMERGENCIES FOR AIDS/ARC VICTIMS BY THE ADULT AND FAMILY SERVICES DIVISION

In our response to Ms. Kristine Gebbie, Deputy Director, Human Resources Administrator Health Division, I believe a couple of paramount general treatment goals for the victims of AIDS/ARC should be stated.

First, in the interest of humane treatment, these patients should receive care to remove them from pain or conditions that will imminently cause pain. Secondly, they should receive care for HIV induced oral conditions which are directly associated with AIDS/ARC. A third consideration which may be more subtle is the maintenance of the ability to masticate food in a group of patients in whom nutrition is a prime consideration.

Below is a specific listing of conditions which I believe should be included in a program of automatic coverage:

1. Acute necrotizing ulcerative gingivitis
2. Acute pulpitis
3. Acute periodontal and periapical abcess and sequellae, i.e. facial cellulitis
4. Osteomyelitis of the jaws
5. Trauma of the oral structures likely to cause severe oral disease or infection
6. Oral conditions associated with AIDS/ARC, particularly biopsy procedures to establish diagnosis
   a) oral candidiasis
   b) oral Herpes Simplex infections - 1^{o}, 2^{o} or other oral infections
   c) Kaposi's sarcoma or other oral lesions which could represent malignancies
   d) hairy leukoplakia
   e) severe gingivitis associated with AIDS/ARC
7. Post radiation or chemotherapy care for those with tumors of the oropharynx

Schools of Dentistry, Medicine and Nursing
University Hospital, Doernbecher Memorial Hospital for Children, Crippled Children's Division, Dental Clinics

NAIC - Advisory Committee on AIDS
Medical/Lifestyle Questions and Underwriting Guidelines

PROPOSED BULLETIN
(Effective Date)

SUBJECT: Medical/Lifestyle Questions on Applications and Underwriting Guidelines Affecting AIDS and ARC

(Recital of applicable authority if needed and purpose of bulletin. Issuance of bulletin is to assist insurers to formulate and design medical/lifestyle questions in applications for and underwriting standards affecting health and/or life insurance coverage in conformity with the fair standards adopted by the NAIC at its December 1986 meeting.)

I. General Propositions

A. No inquiry in an application for health or life insurance coverage, or in an investigation conducted by an insurer or an insurance support organization on its behalf in connection with an application for such coverage, shall be directed toward determining the applicant's sexual orientation.

B. Sexual orientation may not be used in the underwriting process or in the determination of insurability.

C. Insurance support organizations shall be directed by insurers not to investigate, directly or indirectly, the sexual orientation of an applicant or a beneficiary.

II. Medical/Lifestyle Applications Questions and Underwriting Standards

A. No question shall be used which is designed to establish the sexual orientation of the applicant.

B. Questions relating to the applicant having or having been diagnosed as having AIDS or ARC are permissible if they are factual and designed to establish the existence of the condition.

For Example: Insurers should not ask "do you believe you may have . . .?", but rather "do you know or have reasons to know . . .?".

C. Questions relating to medical and other factual matters intending to reveal the possible existence of a medical condition are permissible if they are not used as a proxy to establish the sexual orientation of the applicant, and the applicant has been given an opportunity to provide an explanation for any affirmative answers given in the application.

For Example: "Have you had chronic cough, significant weight loss, chronic fatigue, diarrhea, enlarged glands, . . .?". These types of questions should be related to a finite period of time preceding completion of the application and should be specific. All of the questions above should provide the applicant the opportunity to give a detailed explanation.

D. Questions relating to the applicant's having or having been diagnosed as having or having been advised to seek treatment for a sexually transmitted disease are permissible.

E. Neither the marital status, the "living arrangements," the occupation, the gender, the medical history, the beneficiary designation, nor the zip code or other territorial classification of an applicant may be used to establish, or aid in establishing, the applicant's sexual orientation.

F. For purposes of rating an applicant for health and life insurance, an insurer may impose territorial rates, but only if the rates are based on sound actuarial principles or are related to actual or reasonably anticipated experience.

G. No adverse underwriting decision shall be made because medical records or a report from an insurance support organization shows that the applicant has demonstrated AIDS-related concerns by seeking counselling from health care professionals. This subsection does not apply to an applicant seeking treatment and/or diagnosis.

(Provision for States permitting testing)

H. Whenever an applicant is requested to take an AIDS-related test in connection with an application for insurance, the use of such a test must be revealed to the applicant and his or her written consent obtained. No adverse underwriting decision shall be made on the basis of such a positive AIDS-related test unless an established test protocol* has been followed.

I. Options to be considered by each state.

Alternative A. Insurers should not be permitted to ask an applicant whether he or she has tested positive on an AIDS-related blood test.

Alternative B. Insurers should be permitted to ask an applicant whether he or she has tested positive on an AIDS-related blood test.

Note: "Established test protocol" means the protocol adopted in a particular State. At a minimum, it requires two positive ELISA tests. In some States, it also includes one positive Western blot. It is anticipated that new and more effective ADIS-related tests will be developed which might replace those currently in use.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office for Civil Rights

For information contact:

Carmen Palomera Rockwell, Regional Manager
(206) 442-0473 or (TTY/TDD) 442-7486

Julia Hale-Harbaugh, AIDS Project Coordinator
(206) 442-7483 or (TTY/TDD) 442-7486

Region X
M/S 510
2901 Third Avenue
Seattle, WA 98121

YOUR RIGHTS AS A PERSON WITH AIDS OR RELATED CONDITIONS

Persons with Acquired Immune Deficiency Syndrome (AIDS) or related conditions who feel they have been discriminated against on the basis of handicap may file a complaint with the Office for Civil Rights of the U.S. Department of Health and Human Services. Section 504 of the Rehabilitation Act of 1973 prohibits discrimination based on the disabling effects of AIDS or related conditions. In addition, Section 504 prohibits discrimination against persons who are regarded as having a handicapping condition. Section 504 applies to employers and organizations which receive Federal financial assistance from any Federal department or agency, including the Department of Health and Human Services.

WHAT IS DISCRIMINATION AGAINST PEOPLE WITH AIDS OR RELATED CONDITIONS?

Section 504 of the Rehabilitation Act prohibits discrimination "solely by reason of ... handicap" against any otherwise qualified handicapped person in any program or activity receiving Federal funds or conducted with Federal funds. People with AIDS or related conditions have been discriminatorily terminated from their jobs, denied access to services, or denied medical treatment because of their handicapping condition. Such discrimination is illegal if the institution or organization receives Federal funds.

WHAT CAN YOU DO IF YOU HAVE BEEN DISCRIMINATED AGAINST?

If you, as a person with AIDS or a related condition, feel that you have been discriminated against on the basis of handicap, you may file a complaint with the Office for Civil Rights (OCR) of the U.S. Department of Health and Human Services. OCR is authorized to investigate and resolve complaints of discrimination. Once a complaint is lodged with OCR, the law prohibits the alleged discriminating party from taking any retaliatory actions against a complainant or any person who provides information to OCR regarding a complaint. OCR should be notified immediately in the event of retaliatory action. Under Section 504, you also have the right to consult a private attorney and to seek relief through the filing of a private lawsuit against the organization that you allege discriminated against you.

HOW TO FILE A COMPLAINT WITH THE OFFICE FOR CIVIL RIGHTS

To file a complaint, you or your authorized representative should provide the following information in writing:

- o your name and address;
- o how, why, and when you believe you were discriminated against;
- o the name and address of the institution or organization that discriminated against you; and
- o any other relevant information you have.

Send the information, with your signature, to:

Carmen Palomera Rockwell, Regional Manager
Office for Civil Rights
Department of Health and Human Services
2901 Third Avenue, Mail Stop 510
Seattle, Washington 98121

In most cases you must file your complaint within 180 days of the most recent discriminatory act unless you have a good reason for not filing. OCR staff will review your complaint and determine if it is covered by Section 504 of the Rehabilitation Act of 1973. If the issue in your complaint is not covered, or if the institution or oganization you are complaining about does not receive funding from this Department, OCR will refer your complaint to the appropriate agency that may be able to help you. If your complaint is covered by Section 504, an investigation will be initiated immediately. OCR is expediting the processing of complaints alleging discrimination on the basis of AIDS or AIDS-related conditions. If discrimination is found, OCR will ask the institution or organization to voluntarily correct the problems found. If this is not successful, OCR will be entitled to pursue enforcement proceedings.

THE OFFICE FOR CIVIL RIGHTS

OCR is a division within the U.S. Department of Health and Human Services (DHHS) charged with the responsibility for enforcing Federal laws prohibiting discrimination in programs and activities which receive Federal financial assistance from DHHS. The majority of these laws prohibit discrimination in the provision of services to the people who are intended to benefit from the programs, such as patients at hospitals and clinics, clients of social service programs, and residents of nursing homes and other institutions. Most of these laws, including Section 504, also prohibit discrimination in employment.

Discrimination on the basis of race, national origin, handicap, age, and in some cases sex or religion, are prohibited. If you have any questions concerning the laws enforced by OCR, call the individuals named above or write to the above address.

Rev. 11/86

REPORT ON HIV/AIDS INFECTION AND INSURANCE

HIV/AIDS POLICY COMMITTEE

APRIL 9, 1987

SUPPLEMENT TO:

THE AIDS EPIDEMIC: POLICY RECOMMENDATIONS FOR OREGON'S RESPONSE

REPORT ON HIV/AIDS INFECTION AND INSURANCE

Presented by
the HIV/AIDS Insurance Subcommittee
to the
HIV/AIDS Policy Committee

Cathy Turner
Chair, HIV/AIDS Insurance Subcommittee

March 31, 1987

Adopted by the HIV/AIDS Policy Committee
April 9, 1987

TABLE OF CONTENTS

Insurance Report of the
HIV/AIDS Policy Committee

OVERVIEW

The subcommittee on AIDS/HIV Infection and Insurance met frequently during February and March to consider the questions referred by the parent committee. Because the subcommittee had representation from diverse groups and interests, it was able to consider the questions from a variety of informed viewpoints. This report contains the recommendations of that subcommittee, as ratified by the full Policy Committee.

It quickly became apparent in our discussions that legitimate interests cause different groups to view these issues from strikingly different perspectives. We must consider the interests of promoting public health, of preserving civil rights, of providing health care for those who need it, of maintaining equity among insureds, and of preserving insurer solvency.

Reaching a consensus thus requires compromise, which the committee sought to achieve. Recommendations 1 through 6 of our report reflect consensus on each individual issue.

For the remaining major questions of a medical insurance risk pool, testing applicants for HIV infection, and inquiring about prior test results, consensus resulted only for the recommendations (numbered 7 through 10) taken as a consolidated package. Failure of the 1987 legislature to enact a hospital-medical insurance risk pool would call for the recommendations on testing and inquiring about test results to be withdrawn. No consensus has been reached on what should happen in that situation. The Policy Committee should immediately reconvene, if that bill does not pass, to deal quickly with those issues.

Advisory Committee on
AIDS/HIV Infection and Insurance

Rod Bunnell
Blue Cross Blue Shield of Oregon

Kim Dahlman
Oregon Association of Hospitals

Darrel Dubois
Diagnosed Person with ARC

Ted Falk
Health Care Attorney
Spears, Lubersky, Campbell, Bledsoe, Anderson & Young

Dave Fleming, M.D.
State Health Division

Dick Halton
First Farwest Insurance Company

Tom Koberstein
Cascade AIDS Project

Rudy Miner
Standard Insurance company

James Sampson, M.D.
Good Samaritan Hospital
Oregon AIDS Task Force

Paul Starr
Cascade AIDS Project

Cathy Turner
State Insurance Division

0030c

SUMMARY OF RECOMMENDATIONS

Implementation and Scope. This listing refines the insurance recommendations of the February 1987 AIDS/HIV Policy Committee Report (February, 1987 Report) and consolidates them with those of the Subcommittee on Insurance. Except where otherwise specified, the recommendations pertain to all health and life insurance transactions regulated under Oregon's Insurance Code and are to be implemented by administrative rules of the Insurance Commissioner.

1. Comprehensive Policies. All comprehensive major medical, hospital, or surgical policies should cover AIDS and ARC as they would any other serious medical conditions.

2. Pre-existing Conditions.

   a. Definition. Asymptomatic HIV infection should not be considered a pre-existing condition with respect to subsequent claims related to AIDS or ARC.

   b. Exclusion Periods. The period of exclusion for AIDS or ARC claims, where physical symptoms were present before the coverage date, should be no longer than that for other pre-existing diseases.

3. Cancellation and Non-renewal. Legislation should be enacted to prohibit insurers from cancelling, non-renewing, or increasing premium rates on a person's existing life or health insurance policy because of a change in the health status of, or claims submitted by, that individual.

4. Indigent Care. Because stringent qualifying requirements for publicly-funded assistance leave many persons without access to any third-party payment system, the Committee recommends legislative action to ensure access to medical expense coverage, regardless of income level.

5. Uniform Screening.

   a. Lifestyle. Insurance discrimination based on sexual orientation should be prohibited. No measures may be used in the insurance screening process to determine an applicant's sexual orientation.

   b. Medical. Screening for HIV infection, ARC, and AIDS should be prohibited when not done in conjunction with screening for other health conditions.

6. Remedial Provisions. Given the information available and the specific recommendations of this report, we have not identified any present need for additional remedial provisions.

(SUMMARY RECOMMENDATIONS - continued)

The following recommendations reflect the consensus of the group only when taken as a consolidated package which balances social, civil rights, and public health concerns with those of insurer solvency and equity among insureds.

7. Health Insurance Risk Pool. As part of this package, the legislature should enact Senate Bill 583, establishing a health insurance risk pool to provide coverage for all of those who desire and can pay for it but are unable to obtain it in the conventional market.

8. Testing for HIV Infection. As part of this package, insurance companies may require applicants to take blood tests with certain restrictions:

   a. Reliability of Tests Used. Any insurance company action based on positive test results must be based on either repeated positive ELISA tests confirmed by a Western Blot or another test or test series which the State Epidemiologist finds to be no less accurate.

   b. Informed Consent. Insurance testing should be done only with informed consent.

   c. Disclosure of Test Results. All positive HIV results should be disclosed to a physician or county health department named by the applicant for that purpose, or to the applicant upon specific request. Disclosure to the applicant should be accompanied by appropriate counseling.

9. Inquiries Regarding Past Test Results. As part of this package, insurers may ask whether an applicant has tested positive in any HIV antibody test, subject to the following restrictions.

   a. Types of Questions. General questions asking only whether the applicant has taken such a test, regardless of outcome, should be prohibited.

   b. Confirming Results. A company may not rate or deny coverage merely based on a positive response on an application to a question about past test results. To take such negative action the company must confirm a positive result by the full test protocol described in 8.a. above, through either medical records or current retesting.

10. Group Insurance. As part of this package, certain categories of group insurance, where individual underwriting practices apply, will be subject to the restrictions above on screening for individual policies.

RECOMMENDATIONS ON AIDS/HIV INFECTION AND INSURANCE

Implementation and Scope. Unless otherwise specified, the following recommendations pertain to all health and life insurance transactions regulated under Oregon's Insurance Code and are to be implemented by administrative rules of the Insurance Commissioner.

1. COMPREHENSIVE POLICIES

RECOMMENDATION

All comprehensive major medical, hospital or surgical policies should cover AIDS and ARC as they would any other serious medical conditions (February 1987 Report, Health and Life Insurance recommendation 4, page 56).

Comment

a. For insurance purposes, AIDS and ARC do not differ from other serious medical conditions. No justification exists for singling them out for exclusion.

b. For an applicant who does not qualify for insurance due to HIV positivity, AIDS or ARC, the February report suggested that a health insurance policy might be issued which covered all but costs arising from HIV infection. However, because the medical consequences of AIDS and ARC affect many body systems, it is not practical to provide meaningful coverage while excluding these conditions. It is also not practical to require insurance to be offerred at higher premium rates for infected individuals. The uprated premiums would have to be at a prohibitive rate (for health insurance much higher than insurance available under the risk pool).

   Therefore, although we would not prohibit companies from trying to provide more limited coverage to an infected person, we do not recommend mandating such action.

2. PRE-EXISTING CONDITIONS

a. RECOMMENDATION: DEFINITION

Asymptomatic HIV infection should not be considered a pre-existing condition with respect to subsequent claims related to AIDS or ARC.

Comment.
A pre-existing condition is generally defined as the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care, or treatment. The result of an HIV antibody test should not be considered a "symptom".

b. RECOMMENDATION: EXCLUSION PERIODS

The period of exclusion for AIDS or ARC claims, where physical symptoms were present before the coverage date, should be no longer than that for other pre-existing diseases.

3. CANCELLATION AND NON-RENEWAL OF POLICIES

RECOMMENDATION

Legislation should be enacted to prohibit insurers from cancelling, non-renewing, or increasing premium rates on a person's existing life or health insurance policy because of a post-issue change in the health status of, or claims submitted by, that individual. Draft legislation is included in Exhibit 1. The change should be effective prospectively, to apply to policies issued after passage.

Comment
The Insurance Division is not now approving such policy provisions. Very few, if any, inforce individual policies exist today which give the insurer such a cancellation right.

4. INDIGENT CARE

RECOMMENDATION

The committee supports legislative efforts to ensure access to medical expense coverage without forcing individuals into poverty. We strongly encourage affected parties -- hospital and medical associations, third party payors, citizen representatives and appropriate state agencies -- to aggressively develop approaches that will make health care available for all persons in the state, including those who cannot afford to pay current health insurance premiums. We note the recent introduction of Senate Bill 1006, which deals with the important concepts of catastrophic care and coverage for the medically needy AIDS patient. We urge serious consideration of these proposals. (Exhibit 2)

Comment. The creation of a health insurance risk pool does not resolve the health insurance problem for HIV-infected persons who cannot afford to pay for coverage. Because of stringent qualifying requirements for publicly-funded Medicare or Medicaid assistance, a

substantial proportion of these persons will not have access to any third party payment system. Instead, they will be forced to exhaust already meager financial resources at the same time their health is failing and they are least able to cope with financial stress.

We also recognize that this problem is not AIDS-specific. It affects all uninsurable individuals with limited financial resources. As such, answers must be sought in a forum with the authority and expertise to address the entire need.

5. UNIFORM SCREENING

a. RECOMMENDATION: MEDICAL SCREENING

Screening for HIV infection, ARC and AIDS should be prohibited when not done in conjunction with screening for other health conditions. (February, 1987 Report health and life insurance recommendation 2, p. 55)

b. RECOMMENDATION: LIFESTYLE SCREENING

Insurance discrimination based on sexual orientation should be prohibited. Nondiscrimination rules based on the NAIC Guidelines on Lifestyle Questions should be adopted. (February, 1987 Report, life and health insurance recommendation 3, p.55 and p.140).

Comment
Such rules protect against the danger of rating or declining individuals, or selecting individuals to test, based on sexual orientation.

6. REMEDIAL PROVISIONS

RECOMMENDATION

Given the information available, and the specific recommendations of this report, we have not identified any present need for additional remedial provisions.

Comment
This issue deals with whether an individual has sufficient recourse when insurance laws are violated. The significant remedies already available are described in Exhibit 3.

PACKAGE RECOMMENDATIONS.

The remainder of our recommendations deal with establishing a health insurance risk pool, requiring applicants to take HIV tests to obtain insurance, and asking applicants about prior

test results. To properly balance the social and public health concerns associated with this disease with the costs to insurance companies and to the general insurance-buying public, recommendations 7 through 10 must be seen as a consolidated package. Failure to adopt any one of the items from this package will require re-examination of the remaining issues.

7. HEALTH INSURANCE RISK POOL

a. GENERAL RECOMMENDATION

As part of this package recommendation, the legislature should enact a health insurance risk pool to provide a safety net for all of those who desire and can pay for health insurance but are unable to obtain it in the conventional market. Senate Bill 583 (attached as Exhibit 4) would satisfy this concern and should be adopted. We recommend a number of amendments to the bill. Those are listed in Exhibit 5, and a complete text of those and certain other technical changes is in Exhibit 6. A preliminary cost model is in Exhibit 7.

Comment
Enactment of risk pool legislation addresses one primary concern about insurance company testing: the health insurance alternatives available for those who test positive.

b. CONDITIONAL RECOMMENDATION

If a risk pool is not enacted in the 1987 legislature:

i. the legislature should convene an interim task force on health insurance pooling, and

ii. the recommendations relating to testing and to inquiries about prior results are withdrawn, and a formal mechanism must be established to resolve these issues as quickly as possible.

c. SELF-INSURED PLANS RECOMMENDATION

Federal legislation should be enacted to remove any barriers to assessing the losses of such a program over a base which includes self-insured medical plans.

Comment
A federal law, the Employee Retirement Income Security Act of 1974 (ERISA), regulates all employee benefit plans, with a few exceptions such as governmental plans and church plans. ERISA preempts any state law relating to covered employee benefit plans, except that state insurance regulation is permitted. This means that Oregon can regulate insured plans through the Insurance

Code but cannot regulate self-insured ERISA employee welfare plans. Legal advice furnished to the Committee concludes that any attempt to impose an assessment on such self-insured plans is likely to be preempted by ERISA and is almost certain to embroil the pool in litigation. (see memorandum from Robert H. Thompson, Esq., attached as Exhibit 8)

8. TESTING FOR HIV INFECTION

GENERAL RECOMMENDATION.

As part of our package recommendation, insurance companies may require applicants to take HIV blood tests with certain restrictions described below.

a. TESTING: RELIABILITY OF TESTS USED.

RECOMMENDATION.

Any insurance company action based on positive test results must use either a protocol consisting of repeated positive ELISA tests confirmed by a Western Blot or another test or test series which the State Epidemiologist finds to be no less accurate. These standards should be reviewed and updated periodically in light of currently available conditions and procedures.

Comment
Insurance Companies are not entitled to information on blood test results unless they can be shown to be a reliable factor in determining the risk class of the applicant.

The current protocol of repeated ELISA positivity confirmed by Western Blot appears at this time to meet sufficient reliability standards. (See Wisconsin State Epidemiologist Report on Serologic Tests for the Presence of Antibody to Human T-Lymphotropic Virus Type III.) The high accuracy attributed both to all negative results and to positive results in people currently subject to "high risk" factors, together with the unacceptability of insurance companies classifying individuals on the basis of sexual orientation, leads to this conclusion.

b. TESTING: INFORMED CONSENT

RECOMMENDATION

The general recommendation of the parent committee, that testing be done only with the informed consent of the

applicant, should apply to the insurance setting as follows:

i. Any statute enacted to require informed consent to HIV testing should include the context of insurance physicals or lab tests.

ii. An Insurance Division rule clarifying this requirement in the insurance setting should include specimen language prepared by the Health Division. (See recommendation 2 on page 31 of the February, 1987 Report.)

iii. Any HIV blood test performed in conjunction with an insurance application should have signed authorization by the applicant regarding the specific types of tests involved. This authorization should require the applicant to designate the person to whom positive test results should be reported: a named physician, the county health department, or directly to the applicant.

c. TESTING: DISCLOSURE OF TEST RESULTS.

RECOMMENDATION.

All positive HIV results should be directly or indirectly disclosed to the individual. Information an insurance company acquires through required tests, other than from a physician, should be disclosed for further explanation to a physician or county health department named by the applicant for that purpose. Information should not be disclosed directly to the applicant except upon the individual's specific request, after a renewed opportunity to name a physician. Disclosure to the applicant of HIV positive results should be accompanied by appropriate counseling.

Comment
Existing statutes on use and disclosure of insurance information permit a company which obtains a positive test result to disclose that information either to the applicant or to an attending physician for explanation to the applicant. (ORS 746.640) The latter practice is common and is preferable to having a person not qualified to provide related counseling notify an applicant directly of HIV test results.

In contrast to most other medical results, knowledge of HIV positive results may strongly affect a person's health behavior and public health consequences. Therefore, disclosure should be made of all positive results.

d. TESTING: CONFIDENTIALITY.

RECOMMENDATION.

No recommended changes in existing laws.

Comment
The potential for discrimination outside the insurance arena is real if confidentiality of test results cannot be guaranteed. However, Oregon insurance law restricts the use and disclosure of information in insurance settings. (ORS 746.600 to 746.690.) Given these statutory restrictions on disclosure of information, plus the fact that the committee has no affirmative information on unauthorized disclosures, we feel there are adequate protections in place in this area.

9. INQUIRIES REGARDING PAST TEST RESULTS.

RECOMMENDATION.

As part of our package recommendation, insurance companies may ask whether an applicant has tested positive in any HIV antibody test, subject to the following restrictions.

a. Types of Questions. General questions asking only whether the applicant has taken such a test, regardless of outcome, should be prohibited.

b. Confirming Results. A company may not rate or deny coverage based merely on a positive response on an application to a question about past test results. Before taking such action the company must confirm a positive result to the full test protocol described in 8.a. above, through either medical records or current retesting, or must have been informed that the applicant declines to undergo such further testing.

Comment. The committee considered prohibiting insurers from asking about past positive test results, while permitting testing at time of application. Some persons with practices classified as "high risk" could be discouraged from voluntarily seeking HIV testing, if they know that past positive test results could block future availability of insurance. To the extent that knowledge about one's own HIV antibody status may further encourage the safer sex and IV needle use practice that slows the spread of the disease, any action which would discourage voluntary testing is undesirable.

Balancing the above concern is the consequence of prohibiting questioning about past test results. Insurance companies would then choose between testing all applicants and being forced to insure at standard rates applicants who themselves knew that they presented a significantly higher than standard risk. Consequences for the general insurance-buying public would include higher premiums and increased cost and inconvenience associated with applying for insurance.

The recommendation represents a compromise based on the belief that, with an insurance risk pool in place, questions concerning HIV test results on an insurance application need not be a deterrent for most individuals to seek testing.

10. GROUP INSURANCE

RECOMMENDATION.

As part of the package recommendation, certain categories of group insurance, where individual underwriting practices apply, will be subject to the restrictions above on screening for individual policies. In the group context, the uniform screening requirements apply not only to screening individuals within a group but also to the determination of the level of screening to apply for a particular group.

Comment
The February report recommended no testing, and no questioning about past test results, in group insurance. The stated reason was that group premiums are based on the group's prior claims history, and hence an adequate spread of risk among members of the group would be obtained. However, there are group insurance situations where the selection principles applicable are closer to those for individual insurance. Examples are employers with only a few employees, associations where the members pay the entire premium for their coverage, individuals who do not sign up for group insurance when initially eligible, and individuals with amounts of life or disability insurance significantly larger than the group average.

Because of the ERISA pre-emption of employee benefit plan regulation described in section 7.c., the state cannot force the above group insurance restrictions to apply to self-insured plans. The same restrictions are appropriate for ERISA employers, however, and we urge their voluntary compliance.

List of Exhibits

1. Proposed legislation on cancellation of individual policies.
2. Background memorandum on SB 1006. *
3. Present remedial provisions for insurance code violations.
4. Senate Bill 583
5. Description of amendments suggested to SB583.
6. Engrossed version of amendments to SB583.
7. Cost model for SB583.
8. Robert Thompson's memorandum on self-insured plans. *
9. Bibliography of sources consulted. *

* Available from Bonnie Widerburg, State Health Division

0030c

EXHIBIT I

ID doc 13:2
03/13/87

MEASURE SUMMARY

Prohibits insurers from canceling individual health policies or raising rates because of post-issuance claims of single insured. Repeals provision authorizing health insurer to cancel policy at any time.

A BILL FOR AN ACT

Relating to insurance; creating new provisions; and repealing ORS 743.471.

Be It Enacted by the People of the State of Oregon:

SECTION 1. Section 2 of this Act is added to and made a part of ORS 743.405 to 743.498.

SECTION 2. An individual health insurance policy may not contain any provision permitting the insurer to cancel or not renew the policy or increase the premium rate of the policy because of a post-issuance change in the health status of, or claims submitted by, any individual insured under the policy.

SECTION 3. ORS 743.471 is repealed.

EXHIBIT 2

March 11, 1987

TO: AIDS/HIV Insurance Committee Members

FROM: Kim Dahlman, Oregon Association of Hospitals

RE: CATASTROPHIC CARE FUND

The problem of catastrophic healthcare costs has received much attention lately in regards to the Medicare program and previously with private insurers form such diseases as cancer. The concept of a catastrophic care fund under Medicaid is a natural extension of these concerns. The Oregon Association of Hospitals (OAH) proposal essentially creates two new classes of categorical assistance under the current Title XIX program.

The first part of the proposal centers on payment for AFS day outliers only when the balance remaining after normal DRG reimbursement and Third Party Reimbursement is equal to or exceeds $10,000. This proposal for reimbursement has been in the developmental stage at OAH since early in 1986. The medical indigency position paper of the OAH was previously given to this committee and was the basis for this part of the proposal. The increased awareness of the growing AIDS problem in Oregon due in large part to the HIV/AIDS Policy Committee, brought about the concept of "adding on" another new category to this proposal for AIDS patients. The assumptions we have used to estimate the fiscal impact are based upon, for the most part, those from the policy committee. Realizing that all numbers are open to speculation and question we have made the following assumptions:

a) 1600 AIDS diagnosed cases from 1984 to 1989 - HIV/AIDS Policy Committee.

b) 1375 estimated new cases - HIV/AIDS Policy Committee bar graph representation of projected cases.

c) 800 surviving AIDS diagnosed cases at end of 1989 - assumption based upon estimated life span after diagnosis of AIDS of 12 to 15 months, 1000 diagnosed cases in 1987-89 biennium and Policy Committees recommendations (red book pg. 71).

d) 1000 estimated AIDS diagnosed cases requiring care in 1987-89 biennium - assumption based upon estimated life span, total number of new cases in biennium and carryover cases from prior biennium.

EXHIBIT #2 IS OMITTED FROM THIS REPORT. PLEASE CALL BONNIE WIDERBURG, 229-5806 FOR A COPY.

EXHIBIT III

REMEDIES PROVIDED UNDER THE OREGON INSURANCE CODE

1. ORS 731.988. For violation of any provision of the Insurance Code, any lawful rule or final order of the Commissioner or any final judgment or decree made by any court, the Commissioner may impose a civil penalty of up to $2,000 for each offense, or $10,000 in the aggregate for all such offenses within any three-month period. In addition, the violator may be required to forfeit and pay a civil penalty in an amount determined by the Commissioner up to the amount of profit in any transaction involving such violation.

2. ORS 731.992. For violation of any provision of the Insurance Code for which a greater penalty is not otherwise provided, criminal penalties as for a misdemeanor may be imposed, in addition to any civil penalties.

3. ORS 731.418. For violation or failure to comply with any lawful order of the Insurance Commissioner, any provision of the Insurance Code, or any other items specified in the statute, the Commissioner may revoke or suspend an insurer's Certificate of Authority.

4. ORS 731.252. The Insurance Commissioner may issue a Cease and Desist Order whenever he has reason to believe that any person has been engaged in, is engaging or is about to engage in any violation of the Insurance Code.

5. ORS 731.256. Provides for institution of legal proceedings as the Insurance Commissioner may deem necessary for the enforcement of any provision of the Insurance Code or any order or action made or taken by him. Also provides for institution of criminal prosecution through the Attorney General's office for violation of any provision of the Insurance Code.

6. ORS 743.006 and ORS 743.009. Insurance policy forms, application forms, riders, endorsements or renewal certificates, must be filed and approved prior to use in the state of Oregon. Specifies grounds for which Commissioner may disapprove forms.

7. ORS 743.114. Provides for recovery of plaintiff's attorney's fees in an action for benefits on an insurance policy.

8. ORS 746.680. Provides that if an insurer, agent or insurance support organization discloses information without proper authorization, it shall be liable for damages sustained by the individual about whom the information relates, plus reasonable attorney's fees. Also provides for injunctive relief in order to comply with other provisions of the Insurance Information and Privacy laws.

9. Common Law Remedies. For failure to comply with the provisions of an insurance policy, the person may file suit against the insurer for breach of contract and obtain contract remedies. In addition, the person could file suit against an insurer for its failure to place insurance in effect after satisfying all conditions for purchase.

EXHIBIT 4

64th OREGON LEGISLATIVE ASSEMBLY-1987 Regular Session

Senate Bill 583

Sponsored by Senators BRADBURY, BROCKMAN, CEASE, HAMBY, J. HILL, L. HILL, KERANS, MONROE, RYLES, Representatives AGRONS, ANDERSON, BAUMAN, BROGOITTI, BURTON, BUTSCH, CALOURI, CEASE, DIX, EACHUS, FAWBUSH, FORD, FRENCH, HANNEMAN, HUGO, D. JONES, KOTULSKI, MARKHAM, MASON, McCARTY, McCRACKEN, McTEAGUE, NORRIS, PARKINSON, PETERSON, ROBERTS, SAYLER, SCHROEDER, WHITTY, Senator TIMMS, Representatives PHILLIPS, SOWA (at the request of National Multiple Sclerosis Society, Oregon Chapter American Diabetes Association)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure as introduced.

Creates nonprofit Oregon Health Insurance Pool to offer major medical expense coverage to every eligible person.

A BILL FOR AN ACT

Relating to insurance.

Be It Enacted by the People of the State of Oregon:

SECTION 1. As used in this Act:

(1) "Benefits plan" means the coverages to be offered by the pool to eligible persons pursuant to this Act.

(2) "Board" means the board of directors of the pool.

(3) "Commissioner" means the Insurance Commissioner.

(4) "Division" means the Insurance Division.

(5) "Health insurance" means any hospital, surgical or medical expense incurred policy, any not-for-profit health care service plan contract or health maintenance organization or subscriber contract. Health insurance does not include accident only, disability income, hospital confinement indemnity, dental or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(6) "Health maintenance organization" has the meaning given in ORS 442.015.

(7) "Insured" means any individual resident of this state who is eligible to receive benefits from any insurer or insurance arrangement as defined in this section.

(8) "Insurer" means any insurance company authorized to transact health insurance business in this state and any health maintenance organization.

(9) "Medicare" means coverage under both part A and part B of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq., as amended.

(10) "Member" means all insurers participating in the pool.

(11) "Physician" has the meaning given in ORS 677.010.

(12) "Plan of operation" means the plan of operation of the pool, including articles, bylaws and operating rules, adopted by the board pursuant to this Act.

(13) "Pool" means the Oregon Health Insurance Pool as created by section 2 of this Act.

SECTION 2. (1) There is created a nonprofit entity to be known as the Oregon Health Insur-

NOTE: Matter in **bold face** in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted.

ance Pool. All insurers issuing health insurance in this state on or after the effective date of this Act shall be members of the pool.

(2) The commissioner shall, within 90 days after the effective date of this Act, give notice to all insurers of the time and place for the initial organizational meetings of the pool. The pool members shall select the initial seven member board of directors. The selection of the board shall be subject to approval by the commissioner. The commissioner shall be a member of the pool and shall also serve as the chair of the board or shall designate such chair. The board shall at all times, to the extent possible, include at least one representative of a domestic insurance company licensed to transact health insurance, one representative of a domestic not-for-profit health care service contractor and one member of the general public who is not associated with the medical profession, a hospital or an insurer.

(3) If, within 60 days of the organizational meeting, the board is not selected, the commissioner shall appoint the initial board and appoint an administering insurer.

(4) The board shall submit to the commissioner a plan of operation for the pool and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the pool. The commissioner shall, after notice and hearing, approve the plan of operation provided the plan is determined to be suitable to assure the fair, reasonable and equitable administration of the pool, and provides for the sharing of pool gains or losses on an equitable proportionate basis. The plan of operation shall become effective upon approval in writing by the commissioner consistent with the date on which the coverage under this Act is required to be made available. If the board fails to submit a suitable plan of operation within 180 days after the appointment of the board, or at any time thereafter fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt such rules as are necessary or advisable to effectuate the provisions of this Act. Such rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the board and approved by the commissioner.

(5) In its plan the board shall:

(a) Establish procedures for the handling and accounting of assets and moneys of the pool;

(b) Select an administering insurer or insurers in accordance with this Act and establish procedures for filling vacancies on the board;

(c) Establish procedures for the selection, replacement, term of office and qualifications of the directors of the board and rules of procedures for the operation of the board;

(d) Establish procedures for the collection of assessments from all members to cover pool losses and expenses incurred under the plan during the period for which the assessment is made. The level of payments shall be established by the board, pursuant to this Act. Assessment shall occur at the end of each calendar year. The board may also provide for interim assessments against members of the pool if necessary to assure the financial capability of the pool. Assessments are due and payable within 30 days of receipt of the assessment notice; and

(e) Develop and implement a program to publicize the existence of the plan, the eligibility requirements and procedures for enrollment and to maintain public awareness of the plan.

(6) The pool shall have the general powers and authority granted under the laws of this state to insurance companies licensed to transact the kinds of insurance defined under subsection (5) of section 1 of this Act and the specific authority to:

(a) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this Act, including the authority, with the approval of the commissioner, to enter into

contracts with similar pools of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

(b) Sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against pool members;

(c) Take such legal action as necessary to avoid the payment of improper claims against the pool or the coverage provided by or through the pool;

(d) Establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserves or formulas and perform any other actuarial function appropriate to the operation of the pool. Rates shall not be unreasonable in relation to the coverage provided, the risk experience and expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim costs and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices;

(e) Assess members of the pool in accordance with the provisions of this Act, and to make such advance interim assessments as may be reasonable and necessary for the organizational and interim operating expenses. Any such interim assessments shall be credited as offsets against any regular assessments due following the close of the calendar year;

(f) Issue policies of insurance in accordance with the requirements of this Act;

(g) Appoint from among members appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the pool, policy and other contract design, and any other function within the authority of the pool;

(h) Borrow money to effect the purposes of the Oregon Health Insurance Pool. Any notes or other evidence of indebtedness of the pool not in default shall be legal investments for insurers and may be carried as admitted assets; and

(i) Establish rules, conditions and procedures for reinsuring risks under this Act.

SECTION 3. (1) Any individual person who is a resident of this state shall be eligible for pool coverage if evidence is provided of:

(a) A refusal to issue the insurance for health reasons by one insurer;

(b) A refusal to issue the insurance except with a reduction or exclusion of coverage for a pre-existing health condition for a period exceeding six months; or

(c) A refusal to issue the insurance except at a rate exceeding the pool rate.

(2) Notwithstanding subsection (1) of this section, the board may adopt a list of medical or health conditions for which a person is eligible for pool coverage without applying for health insurance pursuant to this section. Persons who can demonstrate the existence or history of any medical or health conditions on the list adopted by the board are eligible to apply directly to the pool for insurance coverage.

(3) A person is not eligible for coverage under the pool if:

(a) The person is at the time of pool application eligible for health care benefits under ORS chapter 414;

(b) The person has terminated coverage in the pool unless 12 months have lapsed since such termination;

(c) The pool has paid out $1 million in benefits on behalf of the person; or

(d) The person is an inmate of a public institution or is eligible for public programs.

SECTION 4. (1) The board shall select an insurer or insurers through a competitive bidding process to administer the pool. The board shall evaluate bids submitted based on criteria estab-

lished by the board which shall include:

(a) The insurer's proven ability to handle individual accident and health insurance.

(b) The efficiency of the insurer's claim paying procedures.

(c) An estimate of total charges for administering the plan.

(d) The insurer's ability to administer the pool in a cost-effective manner.

(2)(a) The administering insurer shall serve for a period of three years subject to removal for cause.

(b) At least one year prior to the expiration of each three-year period of service by an administering insurer, the board shall invite all insurers, including the current administering insurer, to submit bids to serve as the administering insurer for the succeeding three-year period. Selection of the administering insurer for the succeeding period shall be made at least six months prior to the end of the current three-year period.

(3) The administering insurer shall:

(a) Perform all eligibility and administrative claims payment functions relating to the pool.

(b) Establish a premium billing procedure for collection of premiums from insured persons on a periodic basis as determined by the board.

(c) Perform all necessary functions to assure timely payment of benefits to covered persons under the pool including:

(A) Making available information relating to the proper manner of submitting a claim for benefits to the pool and distributing forms upon which submission shall be made.

(B) Evaluating the eligibility of each claim for payment by the pool.

(d) Submit regular reports to the board regarding the operation of the pool. The frequency, content and form of the report shall be as determined by the board.

(e) Following the close of each calendar year, determine net written and earned premiums, the expense of administration and the paid and incurred losses for the year and report this information to the board and the division on a form as prescribed by the commissioner.

(f) Be paid as provided in the plan of operation for its expenses incurred in the performance of its services.

SECTION 5. (1) Following the close of each calendar year, the pool administrator shall determine the net premiums, the pool expenses of administration and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. Health insurance premiums and subscriber contract charges producing assessments that are less than an amount determined by the board to justify the cost of collection shall not be considered for purposes of determining assessments.

(2) Each insurer's assessment shall be determined by multiplying the total loss from pool operations by a fraction the numerator of which equals that insurer's premiums and subscriber contract charges for health insurance written in the state during the preceding calendar year and the denominator of which equals the total of all premiums and subscriber contract charges written in the state during the preceding calendar year.

(3) If assessments exceed actual losses and administrative expenses of the pool, the excess shall be held at interest and used by the board to offset future losses or to reduce pool premiums. As used in this subsection, "future losses" includes reserves for incurred but not reported claims.

(4)(a) Each member's proportion of participation in the pool shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed with

the board by the member.

(b) Any deficit incurred by the pool shall be recouped by assessments apportioned under subsection (2) of this section by the board among members.

(5) The board may abate or defer, in whole or in part, the assessment of a member if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. In the event an assessment against a member is abated or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth in subsection (2) of this section. The member receiving such abatement or deferment shall remain liable to the pool for the deficiency for four years.

SECTION 6. (1) The pool shall offer major medical expense coverage to every eligible person. Major medical expense coverage offered by the pool shall pay an eligible person's covered expenses, subject to limits on the deductible and coinsurance payments authorized under paragraph (d) of subsection (4) of this section, up to a lifetime limit of $1 million per covered individual. The maximum limit under this subsection shall not be altered by the board, and no actuarial equivalent benefit may be substituted by the board.

(2) When the services and articles are necessary and prescribed by a person licensed and practicing within the scope of the person's profession, covered expenses shall be the prevailing charge in the locality for the following services and articles:

(a) Hospital services.

(b) Professional services for the diagnosis or treatment of injuries, illnesses or conditions, other than mental or dental, which are rendered by a physician or chiropractor, or by other licensed professionals at the direction of a physician or chiropractor.

(c) Drugs requiring a physician's prescription.

(d) Services of a licensed skilled nursing facility for not more than 120 days during a policy year.

(e) Services of a home health agency up to a maximum of 270 services per year.

(f) Use of radium or other radioactive materials.

(g) Oxygen.

(h) Anesthetics.

(i) Prostheses other than dental.

(j) Rental of durable medical equipment, other than eyeglasses and hearing aids, for which there is no personal use in the absence of the condition for which is prescribed.

(k) Diagnostic X-rays and laboratory tests.

(L) Oral surgery for excision of partially or completely unerupted impacted teeth or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

(m) Services of a physical therapist.

(n) Transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition.

(o) Services for diagnosis and treatment of mental and nervous disorders, provided that an insured shall be required to make a 50 percent copayment, and that the payment of the pool shall not exceed $4,000 for outpatient psychiatric treatment.

(3) Covered expenses of the pool shall not include the following:

(a) Any charge for treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or a congenital bodily defect to restore normal bodily functions.

(b) Care which is primarily for custodial or domiciliary purposes.

(c) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician.

(d) That part of any charge for services rendered or articles prescribed by a physician, dentist or other health care personnel which exceeds the prevailing charge in the locality or for any charge not medically necessary.

(e) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual providing the services or articles.

(f) Any expense incurred prior to the effective date of coverage by the pool for the person on whose behalf the expense is incurred.

(g) Dental care except as provided in paragraph (L) of subsection (2) of this section.

(h) Eyeglasses and hearing aids.

(i) Illness or injury due to acts of war.

(j) Services of blood donors and any fee for failure to replace the first three pints of blood provided to an eligible person each policy year.

(k) Personal supplies or services provided by a hospital or nursing home, or any other nonmedical or nonprescribed supply or service.

(4)(a) Premiums charged for coverages issued by the pool may not be unreasonable in relation to the benefits provided, the risk experience and the reasonable expenses of providing the coverage.

(b) Separate schedules of premium rates based on age and geographical location may apply for individual risks.

(c) The pool shall determine the standard risk rate by calculating the average group rate charged by the five largest insurers offering coverages in the state comparable to the pool coverage. In the event five insurers do not offer comparable coverage, the standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. Initial rates for pool coverage shall not be more than 130 percent of rates established as applicable for group risks. Rates subsequently established shall provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves and any other cost factors subject to the limitations described in this section. In no event, however, shall pool rates exceed 150 percent of rates applicable to group risks. All rates and rate schedules shall be submitted annually to the commissioner for approval.

(d) The pool coverage defined in this section shall provide for a choice of deductibles of $500, $1,000 or any other amount determined by the board per annum per individual, and coinsurance of 20 percent, such coinsurance and deductibles in the aggregate not to exceed $1,500 per individual nor $3,000 per family per annum. The deductibles and coinsurance factors may be adjusted annually according to the Medical Component of the Consumer Price Index.

(5) Pool coverage shall exclude charges or expenses incurred during the first six months following the effective date of coverage as to any condition, if:

(a) The condition manifested itself within the six-month period immediately preceding the effective date of coverage in such a manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment; or

(b) Medical advice, care or treatment was recommended or received within the six-month period immediately preceding the effective date of coverage. Such preexisting condition exclusions shall

be waived to the extent to which similar exclusions have been satisfied under any prior health insurance coverage which was involuntarily terminated if the application for pool coverage is made not later than 60 days following the involuntary termination. In such a case, coverage in the pool shall be effective from the date on which such prior coverage was terminated. The board may assess an additional premium of up to 10 percent for coverage provided under the plan in this manner, notwithstanding the premium limitations stated in this Act.

(6)(a) Benefits otherwise payable under pool coverage shall be reduced by all amounts paid or payable through any other health insurance, or insurance arrangement, and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program except Medicaid.

(b) The pool shall have a cause of action against an eligible person for the recovery of the amount of benefits paid which are not for covered expenses. Benefits due from the pool may be reduced or refused as a setoff against any amount recoverable under this paragraph.

SECTION 7. Participation in the pool as members, the establishment of rates, forms or procedures, or any other joint or collective action required by this Act shall not be the basis of any legal action, criminal or civil liability or penalty against the pool or any of its members.

SECTION 8. The pool established pursuant to this Act shall be exempt from any and all taxes assessed by the State of Oregon.

SECTION 9. Any insurer subject to tax liability imposed by ORS 731.816 may offset assessments paid to the pool by it in a calendar year against such tax liability.

SECTION 10. After two years of operation of the pool, the board shall conduct a study of the claims loss experience of the pool and adjust the plan of operation and benefits plan to reflect the findings of the study. The board may also recommend amendments to the Oregon Health Insurance Pool Act to the Legislative Assembly to address the claims loss experience of the pool.

SECTION 11. On and after the date the Oregon Health Insurance Pool becomes operational as provided in this Act, every insurer licensed in this state shall include a notice of the existence of the Oregon Health Insurance Pool in any rejection of any application for health insurance coverage for reasons of the health of the applicant.

Recomended Amendments to SB583

1. The offset against tax liability should parallel the provisions for Oregon Life and Health Insurance Guaranty Association assessments (ORS 734.575(1)), including tax liabilities for corporate excise taxes, gross premium taxes, or fire insurance gross premium taxes and being spread over five years from date of assessment. A carryforward provision should also be added for years in which taxes due are not large enough to permit the full offset otherwise determined.

   Comment. This provision equalizes the permitted tax credits among all pool members. The amortization over five years also decreases the initial cost to the state and smooths out the longer term cost.

2. An emergency clause should be added, making the bill effective upon enactment. The deadlines in Section 2 of the bill would start to run from this date. The bill should require the pool to be operational by April 1, 1988.

3. The legislation should be made a part of the Insurance Code. Among other things, this will clarify certain standard definitions and responsibilities.

4. The pool should be subject to examination and regulation by the Insurance Commissioner, as are the existing insurance guaranty associations (ORS 734.660 and 734.850).

5. Immunity from legal action should be strengthened. (See ORS 734.690 and 734.870 for the existing guaranty associations.)

6. Assessments of any losses from the underwriting risks of the pool should be made over the broadest possible base. The following specific changes should be made:

   Pool membership should include any state or local government units providing self-insured medical insurance programs to their employees.

   The bill should provide that the pool include other self-insured plans to the extent permitted by Federal Law.

7. The listing of specific benefits to be provided by pool coverage should be replaced with broad coverage

guidelines and authority vested in the Insurance Commissioner to approve specific benefits representative of those typically provided by large employers.

Comment. This change will permit the pool to react more quickly to changes in the way medicine is practiced and new benefits available in the marketplace. Specific proposed language is based on the NAIC Alternative 2 version of a risk pool bill.

64th OREGON LEGISLATIVE ASSEMBLY--1987 Regular Session

"HAND ENGROSSED"

Senate Bill 583

Sponsored by Senators BRADBURY, BROCKMAN, CEASE, HAMBY, J. HILL, L. HILL, KERANS, MONROE, RYLES, Representatives AGRONS, ANDERSON, BAUMAN, BROGOITTI, BURTON, BUTSCH, CALOURI, CEASE, DIX, EACHUS, FAWBUSH, FORD, FRENCH, HANNEMAN, HUGO, D. JONES, KOTULSKI, MARKHAM, MASON, McCARTY, McCRACKEN, McTEAGUE, NORRIS, PARKINSON, PETERSON, ROBERTS, SAYLER, SCHROEDER, WHITTY, Senator TIMMS, Representatives PHILLIPS, SOWA (at the request of National Multiple Sclerosis Society, Oregon Chapter American Diabetes Association)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure as introduced.

Creates nonprofit Oregon Health Insurance Pool to offer major medical expense coverage to every eligible person.

A BILL FOR AN ACT

Relating to insurance; creating new provisions; amending ORS 748.555 and 750.055; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. As used in this Act:

(1) "Benefits plan" means the coverages to be offered by the pool to eligible persons pursuant to this Act.

(2) "Board" means the board of directors of the pool.

(3) "Insured" means any individual resident of this state who is eligible to receive benefits from any insurer or self-insurance arrangement.

(4) "Insurer" means any insurer (as defined in ORS 731.106) or fraternal benefit society (as defined in ORS 748.105) required to have a certificate of authority to transact health insurance business in this state and any health care service contractor as defined in ORS 750.005(2).

(5) "Medical insurance" means any hospital, surgical or medical expense incurred policy and any health care service contractor subscriber contract. Medical insurance does not include accident only, disability income, hospital confinement indemnity, dental or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(6) "Medicare" means coverage under both part A and Part B of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq., as amended.

(7) "Member" means all insurers and self-insurance arrangements participating in the pool.

(8) "Physician" has the meaning given in ORS 677.010.

(9) "Plan of operation" means the plan of operation of the pool, including articles, bylaws and operating rules, adopted by the board pursuant to this Act.

(10) "Pool" means the Oregon Medical Insurance Pool as created by section 2 of this Act.

(11) "Self-insurance arrangement" means any plan, program, contract or any other arrangement under which one or more employers, unions or other organizations provide to their employees or members in this state, either directly or indirectly through a trust or third party administrator, health care services or benefits other than through an insurer.

Section 2. (1) There is created a nonprofit entity to be known as the Oregon Medical

NOTE: Matter in bold face in an amended section is new; matter *[italic and bracketed]* is existing law to be omitted

Insurance Pool. The following shall be members of the pool:

(a) All insurers issuing medical insurance in this state on or after the effective date of this Act; and

(b) To the extent consistent with federal law, all self-insurance arrangements which are covered by the Employee Retirement Income Security Act of 1974 as amended and which provide health care benefits in this state on or after the effective date of this Act; and

(c) All self-insurance arrangements which are not covered by the Employee Retirement Income Security Act of 1974 as amended, including but not limited to governmental and church plans, and which provide health care benefits in this state on or after the effective date of this Act.

(2) The commissioner shall, within 90 days after the effective date of this Act, give notice to all insurers and, to the extent feasible, all self-insurance arrangements of the time and place for the initial organizational meetings of the pool. The pool members shall select the initial seven member board of directors. The selection of the board shall be subject to approval by the commissioner. The commissioner shall be a member of the pool and shall also serve as the chair of the board or shall designate such chair. The board shall at all times, to the extent possible, include at least one representative of a domestic insurance company licensed to transact health insurance, one representative of a domestic not-for-profit health care service contractor and one member of the general public who is not associated with the medical profession, a hospital or an insurer.

(3) If, within 60 days of the organizational meeting, the board is not selected, the commissioner shall appoint the initial board and appoint an administering insurer.

(4) The board shall submit to the commissioner a plan of operation for the pool and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the pool. The commissioner shall, after notice and hearing, approve the plan of operation provided the plan is determined to be suitable to assure the fair, reasonable and equitable administration of the pool, and provides for the sharing of pool gains or losses on an equitable proportionate basis. The plan of operation shall become effective upon approval in writing by the commissioner consistent with the date on which the coverage under this Act is required to be made available. If the board fails to submit a suitable plan of operation within 180 days after the appointment of the board, or at any time thereafter fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt such rules as are necessary or advisable to effectuate the provisions of this Act. Such rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the board and approved by the commissioner.

(5) In its plan the board shall:

(a) Establish procedures for the handling and accounting of assets and moneys of the pool;

(b) Select an administering insurer or insurers in accordance with this Act and establish procedures for filling vacancies on the board;

(c) Establish procedures for the selection, replacement, term of office and qualifications of the directors of the board and rules of procedures for the operation of the board;

(d) Establish procedures for the collection of assessments from all members to cover pool losses and expenses incurred under the plan during the period for which the assessment is made. The level of payments shall be established by the board, pursuant to this Act. Assessment shall occur at the end of each calendar year. The board may also provide for interim assessments against members of the pool if necessary to assure the financial capability of the pool. Assessments are due and payable within 30 days of receipt of the assessment notice; and

(e) Develop and implement a program to publicize the existence of the plan, the eligibility requirements and procedures for enrollment and to maintain public awareness of the plan.

(6) The pool shall have the general powers and authority granted under the laws of this state to insurance companies with a certificate of authority to transact health insurance and the specific authority to:

(a) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this Act, including the authority, with the approval of the commissioner, to enter into

contracts with similar pools of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

(b) Sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against pool members;

(c) Take such legal action as necessary to avoid the payment of improper claims against the pool or the coverage provided by or through the pool;

(d) Establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserves or formulas and perform any other actuarial function appropriate to the operation of the pool. Rates shall not be unreasonable in relation to the coverage provided, the risk experience and expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim costs and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices;

(e) Assess members of the pool in accordance with the provisions of this Act, and to make such advance interim assessments as may be reasonable and necessary for the organizational and interim operating expenses. Any such interim assessments shall be credited as offsets against any regular assessments due following the close of the calendar year;

(f) Issue policies of insurance in accordance with the requirements of this Act;

(g) Appoint from among members appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the pool, policy and other contract design, and any other function within the authority of the pool;

(h) Borrow money to effect the purposes of the pool. Any notes or other evidence of indebtedness of the pool not in default shall be legal investments for insurers and may be carried as admitted assets; and

(i) Establish rules, conditions and procedures for reinsuring risks under this Act.

SECTION 3. (1) Except for persons ineligible under subsection (3) of this Section, any individual person who is a resident of this state shall be eligible for pool coverage if:

(a) An insurer, or an insurance company with a certificate of authority in any other state, has made an adverse underwriting decision, as defined in ORS 746.600(1), on medical insurance for health reasons while the person was a resident; or

(b) The person had or has a history of any medical or health conditions on the list adopted by the board under (2).

(2) The board may adopt a list of medical or health conditions for which a person is eligible for pool coverage without applying for medical insurance pursuant to this section.

(3) A person is not eligible for coverage under the pool if:

(a) The person is eligible for health care benefits under ORS chapter 414 or Medicare;

(b) The person has terminated coverage in the pool unless 12 months have lapsed since such termination;

(c) The pool has paid out $1 million in benefits on behalf of the person;

(d) The person is an inmate of or a patient in a public institution; or

(e) The person has, on the date of issue of coverage by the pool, coverage under health insurance or a self-insurance arrangement which is substantially equivalent to coverage under Section 6 of this Act.

(4) A person applying for coverage under the pool shall establish initial eligibility and continuing eligibility by such evidence as the plan of operation shall require.

SECTION 4. (1) The board shall select an insurer or insurers through a competitive bidding process to administer the pool. The board shall evaluate bids submitted based on criteria estab-

lished by the board which shall include:

(a) The insurer's proven ability to handle individual medical insurance.

(b) The efficiency of the insurer's claim paying procedures.

(c) An estimate of total charges for administering the plan.

(d) The insurer's ability to administer the pool in a cost-effective manner.

(2)(a) The administering insurer shall serve for a period of three years subject to removal for cause.

(b) At least one year prior to the expiration of each three-year period of service by an administering insurer, the board shall invite all insurers, including the current administering insurer, to submit bids to serve as the administering insurer for the succeeding three-year period. Selection of the administering insurer for the succeeding period shall be made at least six months prior to the end of the current three-year period.

(3) The administering insurer shall:

(a) Perform all eligibility and administrative claims payment functions relating to the pool.

(b) Establish a premium billing procedure for collection of premiums from insured persons on a periodic basis as determined by the board.

(c) Perform all necessary functions to assure timely payment of benefits to covered persons under the pool including:

(A) Making available information relating to the proper manner of submitting a claim for benefits to the pool and distributing forms upon which submission shall be made.

(B) Evaluating the eligibility of each claim for payment by the pool.

(d) Submit regular reports to the board regarding the operation of the pool. The frequency, content and form of the report shall be as determined by the board.

(e) Following the close of each calendar year, determine net written and earned premiums, the expense of administration and the paid and incurred losses for the year and report this information to the board and the division on a form as prescribed by the commissioner.

(f) Be paid as provided in the plan of operation for its expenses incurred in the performance of its services.

Section 5. (1) Following the close of each calendar year, the board shall determine the net premiums (premiums less administrative expense allowances), the pool expenses of administration and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. Medical insurance premiums and subscriber contract charges and benefits paid by a self-insurance arrangement producing assessments that are less than an amount determined by the board to justify the cost of collection shall not be considered for purposes of determining assessments. The amount of the assessment shall be as follows:

(a) Each insurer's assessment shall be determined by multiplying the total loss from pool operations by a fraction the numerator of which equals that insurer's premiums and subscriber contract charges for medical insurance written in the state during the preceding calendar year and the denominator of which equals the total of all medical insurance premiums and subscriber contract charges written in the state and 110 percent of all claims paid by member self-insurance arrangements in the state during the preceding calendar year.

(b) Each member self-insurance arrangement's assessment shall be determined by multiplying the total loss from pool operation by a fraction, the numerator of which equals 110% of the benefits paid by that self-insurance arrangement on behalf of insured in this state during the preceding calendar year and the denominator of which equals the total of all medical insurance premiums, subscriber contract charge and 110% of all benefits paid by member self-insurance arrangements made on behalf of insured in this state during the preceding calendar year. Member self-insurance arrangements shall report to the board claims payments made in this state on an annual basis on a form prescribed by the commissioner.

(c) The board may recommend, and the commissioner may adopt, rules adjusting the assessment formula in this subsection to achieve equal treatment between insurers and self-insurance arrangements.

(3) If assessments exceed actual losses and administrative expenses of the pool, the excess shall be held at interest and used by the board to offset future losses or to reduce pool premiums. As used in this subsection, "future losses" includes reserves for incurred but not reported claims.

(4)(a) Each member's proportion of participation in the pool shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed with

the board by the member.

(b) Any deficit incurred by the pool shall be recouped by assessments apportioned under subsection (2) of this section by the board among members.

(5) The board may abate or defer, in whole or in part, the assessment of a member if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. In the event an assessment against a member is abated or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth in subsection (2) of this section. The member receiving such abatement or deferment shall remain liable to the pool for the deficiency for four years.

SECTION 6. (1) The pool shall offer major medical expense coverage to every eligible person.

(2) The coverage to be issued by the pool, its schedule of benefits, exclusions and other limitations, shall be established through rules promulgated by the Commissioner, taking into consideration the advice and recommendations of the pool members. In the absence of such rules, the pool shall use the minimum benefits prescribed by Section 6 (Alternative 1) of the Model Health Insurance Pooling Mechanism Act of the National Association of Insurance Commissioners (1983).

1/ If this amendment to subsections 6(1) through 6(3) is not made, then see alternative amendm attached as an Appendix.

SB 583

(3) In establishing the pool coverage, the Commissioner shall take into consideration the levels of medical insurance provided in the state and such medical economic factors as may be deemed appropriate and shall promulgate benefit levels, deductibles, coinsurance factors, exclusions and limitations determined to be generally reflective of, and commensurate with, medical insurance provided through a representative number of large employers in the state.

(4)(a) Premiums charged for coverages issued by the pool may not be unreasonable in relation to the benefits provided, the risk experience and the reasonable expenses of providing the coverage.

(b) Separate schedules of premium rates based on age and geographical location may apply for individual risks.

(c) The pool shall determine the standard risk rate by calculating the average group rate charged by the five largest insurers offering coverages in the state comparable to the pool coverage. In the event five insurers do not offer comparable coverage, the standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. Initial rates for pool coverage shall not be more than 130 percent of rates established as applicable for group risks. Rates subsequently established shall provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves and any other cost factors subject to the limitations described in this section. In no event, however, shall pool rates exceed 150 percent of rates applicable to group risks. All rates and rate schedules shall be submitted annually to the commissioner for approval.

(d) The pool coverage defined in this section shall provide for a choice of deductibles of $500, $1,000 or any other amount determined by the board per annum per individual, and coinsurance of 20 percent, such coinsurance and deductibles in the aggregate not to exceed $1,500 per individual nor $3,000 per family per annum. The deductibles and coinsurance factors may be adjusted annually according to the Medical Component of the Consumer Price Index.

(5)(a) Pool coverage shall exclude charges or expenses incurred during the first six months following the effective date of coverage as to any condition:

(i) Which had manifested itself within the six-month period immediately preceding the effective date of coverage in such a manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment; or

(ii) For which medical advice, care or treatment was recommended or received within the six-month period immediately preceding the effective date of coverage.

(b) Such preexisting condition exclusions shall be waived to the extent to which similar

exclusions, if any, have been satisfied under any prior health insurance coverage which was involuntarily terminated if the application for pool coverage is made not later than 60 days following the involuntary termination. In such a case, coverage in the pool shall be effective from the date on which such prior coverage was terminated. The board may assess an additional premium of up to 10 percent for coverage provided under the plan in this manner, notwithstanding the premium limitations stated in this Act.

(6)(a) Benefits otherwise payable under pool coverage shall be reduced by all amounts paid or payable through any other medical or health insurance, or self-insurance arrangement, and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program except Medicaid.

(b) The pool shall have a cause of action against an eligible person for the recovery of the amount of benefits paid which are not for covered expenses. Benefits due from the pool may be reduced or refused as a setoff against any amount recoverable under this paragraph.

(7) The mandated benefit statutes that apply to individual health insurance shall apply to pool coverage.

(8) Pool coverage may be furnished through a health care service contractor or such alternative delivery system as will contain costs while maintaining quality of care.

Section 7. Neither participation in the pool as members, the establishment of rates, forms, or procedures, nor any other action taken in the performance of the powers and duties under this Act shall be the basis of any legal action, criminal or civil liability or penalty against the pool, any of its members, its board, the commissioner, or any of their agents or employees.

SECTION 8. The pool established pursuant to this Act shall be exempt from any and all taxes assessed by the State of Oregon.

Section 9. (1) A member may offset the assessment described in section 5 of this Act first against its corporate excise tax imposed under ORS 317.070, its gross premiums tax imposed under ORS 731.816 or both, and second against its fire insurance gross premiums tax imposed under ORS 731.820, in that order. On recommendation of the board, the commissioner may adopt rules allowing a substantially equivalent tax offset for self-insurance arrangements or their sponsors.

(2) Any offset shall be taken at a rate of 20 percent of the amount of the assessment for each of the five calendar years following the year in which the assessment was paid. If the member has insufficient tax liability in any year to take advantage of all or part of the offset resulting from an assessment, the unused portion of the offset may be carried forward to subsequent tax years as permitted by ORS 317.476. If a member ceases doing business, all uncredited assessments may be credited against its tax liabilities referred to in this subsection for the year in which it ceases doing business.

SECTION 10. After two years of operation of the pool, the board shall conduct a study of the claims loss experience of the pool and adjust the plan of operation and benefits plan to reflect the findings of the study. The board may also recommend amendments to this Act to the Legislative Assembly to address the claims loss experience of the pool.

SECTION 11. On and after the date the pool becomes operational as provided in this Act, every insurer or self-insurance arrangement shall include a notice of the existence of the Oregon Medical Insurance Pool in any adverse underwriting decision on medical insurance, as defined in subsection 3(1)(a) of this Act, for reasons of the health of the applicant.

for reasons of the health of the applicant.

SECTION 12. (1) The pool shall be subject to examination and regulation by the commissioner.

(2) The following provisions of the Insurance Code shall apply to the pool to the extent applicable and not inconsistent with the express provisions of this Act: _____.[2/]

(3) For the purposes of this section only, the pool shall be deemed an insurer, pool coverage shall be deemed individual health insurance, and pool coverage contracts shall be deemed policies.

SECTION 13. Sections 1 through 12 of this Act are added to, and made a part of, the Insurance Code.

SECTION 14. ORS 748.555 is amended to read:

748.555 **Other provisions applicable to fraternal benefit societies.** (1) The following provisions of the Insurance Code shall apply to fraternal benefit societies to the extent so applicable and not inconsistent with the express provisions of this chapter:

(a) ORS 731.004 to 731.026, 731.032 to 731.154, 731.162, 731.166, 731.170, 731.204 to 731.356, 731.378 to 731.434, 731.450, 731.454, 731.504, 731.508, 731.512, 731.574 to 731.620, 731.640, 731.644 to 731.652, 731.804 and 731.844 to 731.992.

(b) ORS 732.245, 732.250, 732.320 and 732.325.

(c) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733,210 733.510 to 733.570, 733.590 to 733.680 and 733.710 to 733.780.

(d) ORS chapter 734.

(e) ORS 743.003 to 743.012, 743.018 to 743.030, 743.039 to 743.054, 743.060, 743.069, 743.078, 743.084 to 743.108, 743.114, 743.116, 743.123, 743.350 to 743.370 and 743.558.

(f) ORS 744.005 to 744.265.

(g) ORS 746.005 to 746.140, 746.160, 746.180, 746.220 to 746.370 and 746.600 to 746.690.

(h) This 1987 Act.

(2) For the purposes of this section, fraternal benefit societies shall be deemed insurers and benefit certificates issued by such societies shall be deemed policies.

SECTION 15. ORS 750.055 is amended to read:

750.055 **Other provisions applicable to health care service contractors.** (1) The following provisions of the Insurance Code shall apply to health care service contractors to the extent so applicable and not inconsistent with the express provisions of this chapter:

[2/] See ORS 748.555, 750.055(1).

(a) ORS 731.004 to 731.150, 731.162, 731.204 to 731.362, 731.382, 731.386, 731.390, 731.398 to 731.430, 731.450, 731.454, 731.504, 731.508, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.804 and 731.844 to 731.992.

(b) ORS 732.230, 732.245, 732.250, 732.320, 732.325 and 732.505 to 732.595.

(c)(A) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.700 to 733.780, apply to not for-profit health care service contractors.

(B) ORS chapter 733 applies to for-profit health care service contractors.

(d) ORS chapter 734.

(e) ORS 743.003 to 743.011, 743.012, 743.018 to 743.030, 743.037 to 743.108, 743.114, 743.116, 743.119 to 743.128, 743.350 to 743.370, 743.402, 743.412, 743.492, 743.495, 743.498, 743.527, 743.529, 743.549 to 743.555, 743.800 to 743.333 and 743.850 to 743.890.

(f) ORS 743.522 and 743.528, except that individual policies may be issued to the persons or families insured in lieu of issuance of a single group policy as referred to in ORS 743.522. An individual policy issued under this paragraph shall be considered the statement of the essential features of the insurance coverage required under ORS 743.528(2).

(g) ORS 744.005 to 744.265.

(h) ORS 746.005 to 746.140, 746.160, 746.180, 746.220 to 746.370 and 746.600 to 746.690.

(i) ORS 743.135, except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act unless the patient is referred by a physician associated with a group practice health maintenance organization.

(j) ORS 743.557 and 743.558, except that group practice or staff health maintenance organizations which are federally qualified pursuant to Title XIII of the Public Health Service Act shall be deemed to comply with the requirements of ORS 743.557 and 743.558.

(k) This 1987 Act.

(2) For the purposes of this section only, health care service contractors shall be deemed insurers.

(3) Any for-profit health care service contractor organized under the laws of any other state which is not governed by the insurance laws of such state, will be subject to all requirements of ORS chapter 732.

(4) The commissioner may, after notice and hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025 and 752.045 that are deemed necessary for the proper administration of these provisions.

SECTION 16. This Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this Act takes effect on its passage. The pool shall become operational as soon as reasonably possible and in any event no later than April 1, 1988.

APPENDIX

Alternative Section 6

If the foregoing amendments to subsections 6(1) through 6(3) are not adopted, then the following should be substituted:

Major medical expense coverage offered by the pool shall pay an eligible person's covered expenses, subject to limits on the deductible and coinsurance payments authorized under paragraph (d) of Subsection (4) of this section and subject to any alternative arrangement under subsection (8) of this Section, up to a lifetime limit of $1 million per covered individual. The maximum limit under this subsection shall not be altered by the board, and no actuarial equivalent benefit may be substituted by the board.

(2) When the services and articles are medically necessary and are prescribed by a person licensed and practicing within the scope of the person's profession, covered expenses shall be the lesser of the actual charge or the prevailing charge in the locality for the following services and articles, subject to subsection 6(9) of this section.

(a) Services of a health care facility, other than a long term care facility, as defined in ORS 442.015(16).

(b) Professional services for the diagnosis or treatment of injuries, illnesses or conditions, other than mental or dental, which are rendered by a physician or chiropractor, or by other licensed professionals at the direction of a physician or chiropractor.

(c) Drugs requiring a prescription.

(d) Services of a skilled nursing facility, as defined in ORS 442.015(16)(c)(A), for not more than 120 days during a policy year.

(e) Services of a home health agency, as defined in ORS 443.005(2), up to a maximum of 270 services per year.

(f) Use of radium or other radioactive materials.

(g) Oxygen.

(h) Anesthetics.

(i) Prostheses other than dental.

(j) Rental of durable medical equipment, other than eyeglasses and hearing aids, for which there is no personal use in the absence of the condition for which is prescribed.

(k) Diagnostic X-rays and laboratory tests.

(L) Oral surgery for excision of partially or completely unerupted impacted teeth or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

(m) Services of a licensed physical therapist, as defined in ORS 688.010(3).

(n) Transportation provided by a licensed ambulance service to the nearest health care facility qualified to treat the condition.

(o) Coverage required under subsection (7) of this section.

(p) Emergency dental services necessary to avoid systemic infection.

(q) Services of a hospice.

(3) Subject to subsection 6(9) of this Section, covered expenses of the pool shall not include the following:

(a) Any charge for treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or a congenital bodily defect to restore normal bodily functions.

(b) Care which is primarily for custodial or domiciliary purposes.

(c) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician.

(d) That part of any charge for services rendered or articles prescribed by a physician, dentist or other health care personnel which exceeds the prevailing charge in the locality or for any charge not medically necessary.

(e) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual providing the services or articles.

(f) Any expense incurred prior to the effective date of coverage by the pool for the person on whose behalf the expense is incurred.

(g) Dental care except as provided in paragraphs (L) and (p) of subsection (2) of this section.

(h) Eyeglasses and hearing aids.

(i) Illness or injury due to acts of war.

(j) Services of blood donors and any fee for failure to replace the first three pints of blood provided to an eligible person each policy year.

(k) personal supplies or services provided by a health care facility, or any other nonmedical or nonprescribed supply or service.

New Subsection 6(9) is added before p. 7, line 16:

(9) The coverage to be issued by the pool, its schedule of benefits, exclusions and other limitations, may be established or modified through rules promulgated by the Commissioner, taking into consideration the advice and recommendations of the pool members.

Exhibit 7

Cost Model for SB 583

The major cost to the state of the proposed Health Insurance Pool is from the tax credits granted for pool assessments. Attached is a very rough model of the factors entering into such a calculation. It gives a general idea of the timing and order of magnitude of the costs involved. Clearly results will vary directly with the number of individuals who enroll and the actual loss ratios incurred.

The model does show that the cost to the state for the initial '87 - '89 biennium will be relatively small. That cost may be expected to increase rapidly, however, as enrollment climbs, the pre-existing condition exclusion period wears off, and the deferred credits from initial assessments add up.

Here are some general facts to use as a frame of reference in considering the appropriate assumptions for the model:

Premiums in other states vary by age at issue and deductible, and range from under $1000 to over $3000 per year.

Pool enrollment in other states ranges from 600 to over 10,000 individuals. In terms of percentages, enrollment goes from 1/100 of 1% to 3/10 of 1% of population.

Total Medical Insurance premiums in Oregon are approximately $1 Billion per year.

0030c -

10-Apr-97 --Risk Pool Summary Costs

Low Cost/Low Volume

Annual premium		Loss ratio		
initp	1,000 (1)	first6	0.400 (6)	
trendp	0.100 (2)	ult	1.500 (7)	
Enrollment		Admin. load		
first0	500 (3)	exps	0.120 (8)	
addl/Q	250 (4)			
max	2,000 (5)			

year	Quarter	pool gain (loss)	member assess't	tax credit		biennium cost to state
1988	1	0	$1000s			$1000s
1988	2	61				
1988	3	94				
1988	4	(19)	(137)	(27)	prelim.	
			0	0	final	
1989	1	(62)				'87-'89
1989	2	(107)				0
1989	3	(154)				
1989	4	(204)	390		prelim.	
			390	78	final	
1990	1	(209)				
1990	2	(214)				
1990	3	(219)				
1990	4	(224)	866		prelim.	
			866	251	final	
1991	1	(230)				'89-'91
1991	2	(235)				329
1991	3	(241)				
1991	4	(247)	952		prelim.	
			952	442	final	
1992	1	(253)				
1992	2	(259)				
1992	3	(265)				
1992	4	(271)	1,047		prelim.	
			1,047	651	final	
1993	1	(278)				'91-93
1993	2	(285)				1,093
1993	3	(291)				
1993	4	(298)	1,152		prelim.	
			1,152	881	final	

Middle Cost/Middle Volume

Annual premium		Loss ratio		
initp	1,000 (1)	first6	0.500 (6)	
trendp	0.100 (2)	ult	2.000 (7)	
Enrollment		Admin. load		
first0	750 (3)	exps	0.120 (8)	
addl/Q	300 (4)			
max	3,000 (5)			

pool gain (loss)	member assess't	tax credit		biennium cost to state
0	$1000s			$1000s
73				
105				
(164)	(13)	(3)	prelim.	
	0	0	final	
(261)				'87-'89
(362)				0
(467)				
(578)	1,654		prelim.	
	1,654	331	final	
(693)				
(762)				
(780)				
(799)	3,035		prelim.	
	3,035	938	final	
(819)				'89-'91
(838)				1,269
(859)				
(879)	3,395		prelim.	
	3,395	1,617	final	
(900)				
(922)				
(944)				
(967)	3,734		prelim.	
	3,734	2,364	final	
(990)				'91-93
(1,014)				3,980
(1,039)				
(1,064)	4,107		prelim.	
	4,107	3,185	final	

(1) Initial annual premium per person
(2) Annual increase in premiums (inflation, etc.)
(3) Enrollment in initial quarter
(4) New enrollees each additional quarter
(5) Maximum pool enrollment
(6) Loss ratio for first 6 months of enrollment (during pre-existing exclusion period)
(7) Loss ratio after first 6 months of enrollment
(8) Portion of premium used for administrative expenses

EXHIBIT 8

M E M O R A N D U M

To: Insurance Subcommittee of HIV/AIDS Policy Committee — March 24, 1987

From: Robert H. Thomson
Weiss, DesCamp & Botteri, A Professional Corporation

Subject: Insurance Risk Pools -- ERISA Preemption

The Insurance Subcommittee has asked our advice as to whether a number of proposals for Oregon legislation providing funding for an Insurance Risk Pool are preempted by the federal Employee Retirement Income Security Act of 1974, as amended ("ERISA"). We have drawn the following general conclusions, which are discussed in detail below:

1. Except to the extent allowed by conclusion 3, below, a proposal which would result in a mandatory assessment against employee benefit plans covered by ERISA would be preempted.

2. Except to the extent allowed by conclusion 3, below, a proposal which would provide favorable tax benefits with respect to ERISA-covered plans voluntarily accepting an assessment while denying those benefits to plans which don't would very probably be preempted.

3. Either proposal 1 or 2, above, if expressed in the form of a law which regulates insurance, would probably not be preempted to the extent that the assessment is against an employee welfare benefit plan covered by ERISA which qualifies as a "multiple employer welfare arrangement," which is not fully insured and which has not been exempted from broad state insurance regulation by the U.S. Secretary of Labor.

4. A proposal which would assess only insurance carriers would not be preempted.

5. A proposal which would assess plans, such as governmental or church plans, which are exempt from ERISA, as well as insurance carriers, would not be preempted.

6. A proposal which would impose a tax on hospitals as such, or on employers as such, would not be preempted.

Statement of Facts

The Insurance Subcommittee is formulating proposals to submit to its parent, the HIV/AIDS Policy Committee, which in turn is expected to submit proposals to the Oregon Legislature. Among the expected proposals is one for

EXHIBIT #8 IS OMITTED FROM THIS REPORT. PLEASE CALL BONNIE WIDERBURG, 229-5806 FOR A COPY.

EXHIBIT 9

INSURANCE AND AIDS/HIV INFECTION ADVISORY SUBCOMMITTEE

BIBLIOGRAPHY OF MATERIALS CONSULTED

Revised March 26, 1987

I. HIV/AIDS Policy Committee

1.1 Parent Committee Report: "The AIDS EPIDEMIC: Policy Recommendations for Oregon's Response," (Feb. 1, 1987).

1.2 Parent Committee Working Papers:

1.2.1 Report of HTLV-III AIDS Policy Subcommittee on Financing, Insurance and Costs (June 6, 1986).

1.2.2 Minutes, HTLV-III AIDS Committee Meeting (Sept. 25, 1986).

1.2.3 AIDS and Insurance; Summary of Conclusions and Open Questions from Sept. 25, 1986 meeting.

1.2.4 Minutes, HTLV-III AIDS Policy Committee Meeting (Oct. 9, 1986).

1.2.5 Minutes, HTLV-III AIDS Policy Committee Meeting (Nov. 13, 1987).

1.2.6 Draft Report, Health and Life Insurance (Dec. 4, 1986).

1.2.7 Draft Report, Insurance Risk Pool (Dec. 4, 1986).

1.2.8 Letter: Keith Putnam, Administrator of Adult Family Services to Bonnie Widerburg, Health Division. Re: HIV/AIDS Policy Report - Final Draft (Dec. 16, 1986).

1.2.9 Memo: Ted Falk to HIV/AIDS Committee. Re: Draft Report (Dec. 18, 1986).

1.2.10 Letter: Sandy Houglan, R.N., Pres. of Oregon Nurses Assoc. to Kristine Gebbie, Health Division. Re: Draft Report (Dec. 19, 1986).

EXHIBIT #9 IS OMITTED FROM THIS REPORT. PLEASE CALL BONNIE WIDERBURG, 229-5806 FOR A COPY.

HIV/AIDS POLICY COMMITTEE MEMBERS

Carl Berggren, M.A., C.R.C., Mid-Oregon AIDS Health Education Support Services, Inc.

Holly Berman, M.S.W., Senior Services Division

Jack Bush, Ph.D., Correctional Treatment Program, Mental Health Division

Darrel DuBois, Person With AIDS

Pat Ellis, Department of Education, Special Education & Services Division

Marge Erwin, R.N., B.S.N., Kaiser Permanente, Representing A.F.L.-C.I.O.

Ted Falk, J.D., Ph.D., Health Care Attorney, Spears,Lubersky, Campbell, Bledsoe, Anderson and Young

Michael Garland, Ph.D., Dept. of Public Health & Preventive Medicine, Oregon Health Sciences University

Kristine M. Gebbie, R.N., M.N., CHAIR; Health Division

George G. Goldthwaite, Oregon Public Advisory Board

Richard Grant, State Health Planning and Development Agency

Edward Hendricks, M.D., M.P.H., Adult and Family Services Division

Catherine Knox, Corrections Division

Thomas Koberstein, Cascade AIDS Project, Ecumenical Ministries

Vicky Koenig, R.N., M.P.H., Portland VA Medical Center, Representing Oregon Association for Home Care

Jeffrey Kushner, Office of Alcohol and Drug Abuse

Sherral Landsiedel, R.N., B.S.N., Lane County Health Services, Representing Oregon Nurses Association

Robert Lawrence, M.D., Kaiser Permanente Immune Deficiency Clinic, Representing Oregon AIDS Task Force

Mark Loveless, M.D., Representing Oregon Medical Association

Gretchen Miller, University of Oregon Law School, Representing Willamette AIDS Resource Council

John Munro, Government Affairs Council, Representing Assoc. Oregon Industries

Gary Oxman, M.D., Multnomah Co. Dept. of Human Services, Health Services Div.

Tia Plympton, M.S.W., Cascade AIDS Project

Sue Sakai, M.S.W., Good Samaritan Hospital, Representing Oregon Association of Hospitals

James Sampson, M.D., Good Samaritan Hospital, Representing Oregon AIDS Task Force

Charles P. Schade, M.D., Multnomah County Health Officer, Representing Conference of Local Health Officials

Wayne Sepeda, Person With AIDS

Paul Starr, M.S.W., Cascade AIDS Project

Cathy Turner, F.S.A., Insurance Division

Thomas Ward, M.D., Portland VA Medical Center, Representing Oregon AIDS Task Force

Peggy Zach, R.N., B.S. Benedictine Nursing Center, Representing Long Term Care Institutions