OREGON

DISCLAIMER: The views, statistical analysis, findings, and opinions expressed herein are not necessarily those of the Office of Minority Health, the Office of Public Health and Science nor the Department of Health and Human Services. The National Health Law Program, Inc. (NHeLP), under contract #282-00-0026, reviewed and analyzed existing state policies related to collecting racial and ethnic data by managed care organizations and health insurers. The information in this draft report contains the findings of NHeLP and not that of the Office of Minority Health, the OPHS, nor the U. S. Department of Health and Human Services. The study was conducted between October 2000 and May 2001. The policies and/or data per state may have changed since that time. The findings that have been updated in this draft report are the U.S. Census data (updated so that all data is from the 2000 Census) and the Center for Medicare & Medicaid Services (CMS)/HHS Medicaid data (updated from the June 30, 2000 to the December 31, 2002 reports).

OREGON

A. General and Health Demographics

Total Population	3,421,399	
Percent Black Population	1.6	
Percent American Indian and Alaskan Native Population	1.2	
Percent Asian Population	2.9	
Percent Native Hawaiian and Other Pacific Islander Population	0.2	
Percent Hispanic Population (of any race)	8.0	
Percent White Population	83.5	
Other (some other race and two or more races)	2.5	
Language Use - 2000 census data		
Percent Limited English Proficiency (LEP) Population	3.27	(5.91)
Health Care Delivery Profile		
Percent of Total Non-elderly Population Privately Insured (1997-99)	71.5	
Percent of Total Population Enrolled in HMOs	38.7	
Medicaid Enrollment (as of December 31, 2002)	427,547	(12.50%)
Medicaid Managed Care Enrollment	372,756	(87.18%)
Percent of Total Non-elderly Population Uninsured (1997-99)	15.8	

B. Collection and Reporting of Racial and Ethnic Data by Health Insurers and Managed Care Organizations

1. Statutes, Regulations, Policies and Other Written Materials

The term "health insurer" in Oregon covers any entity that provides health insurance,[1] including insurance companies,[2] health care services contractors (HCSC), health maintenance

[1] Or. Code §§ 731.162 (health insurance); *see e.g.*, Or. Code §§ 743.730 and 743.801.
[2] Or. Code §§ 731.106.

organizations (HMO),[3] and managed care organizations (MCOs).[4] This state summary will use the term "health insurer" to refer to all of these entities, but any distinctions among the types of health insurance entities will be noted if relevant to the issue being discussed.

Health insurers are regulated by the Department of Consumer and Business Services (DCBS),[5] which approves all basic policy forms and applications.[6] There are no statutes or regulations requiring or prohibiting the collection of race, ethnicity or primary language data by health insurers. However, all insurers of health plans in the state must meet accessibility and quality assurance requirements. These include having a description of assistance provided to non-English-speaking enrollees and a written policy that recognizes the rights of enrollees.[7]

All insurers offering managed health insurance must file an annual summary with DCBS. The summary should describe, among other things, access to services for enrollees, including those with special needs, identification and resolution of access problems, and communication with enrollees.[8] It must also describe the insurer's quality assessment (QA) program, which normally includes consumer satisfaction surveys. The plans are encouraged to make their QA programs consistent with the National Committee on Quality Assurance (NCQA) Health Plan Employer Data and Information Set (HEDIS).[9] The consumer survey portion of that data set includes both race and ethnicity fields, so it is possible that at least some plans in Oregon collect this type of information.

2. Discrimination

Although there is a rule that prohibits unfair discrimination in the provision of insurance based on race, it does not apply to health insurers.[10] The primary anti-discrimination statute regulating the insurance industry does not explicitly contain the terms race, ethnicity or national origin. It prohibits any unfair discrimination between individuals of the same class or with similar risks in the availability of insurance, in the application of rates for insurance, in the dividends or other benefits payable under insurance policies, or in any other terms or conditions of insurance policies.[11]

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[3] Or. Code § 750.005. An HCSC is a group of physicians or hospitals which accepts prepayment for health care services, and a health maintenance organization is a type of HCSC. The term HCSC will be used for those plans under the jurisdiction of DCBS, and HMO will be used to refer to prepaid health service contracts which the Department of Human Services (DHS) is authorized to enter into for its Medicaid program and SCHIP. Or. Code § 414.630.

[4] Or. Code §§ 743.814.

[5] Or. Code §§ 731.016, 731.236 and 743.010.

[6] Or. Code § 742.003.

[7] Or. Code §§ 743.804(1) & 743.804(5)(o).

[8] Or. Code § 743.817(1) and Or. Admin. Rule 836-053-1190(1).

[9] *Id.* at 836-053-1170(3).

[10] Or. Admin. Rule 836-081-0010.

[11] Or. Code § 746.015.

Oregon does have a general public accommodations statute that prohibits discrimination on the basis of race, religion, sex, marital status, color or national origin,[12] but the Oregon Supreme Court has held that the statute does not apply to insurance.[13]

3. Confidentiality

All health insurers "must protect the confidentiality of specified patient information and records and afford enrollees the opportunity to approve or deny the release of personally identifiable medical information by the insurer, except as otherwise required by law."[14] Insurers must establish standards for the collection, use, and disclosure of information gathered by them in connection with insurance transactions.[15] Moreover, although records of public agencies such as DCBS are considered public records, medical and confidential information is exempt from public disclosure.[16]

C. Collection and Reporting of Racial and Ethnic Data by Other Health Care Entities

1. Department of Human Services (DHS)

a. Statutes, Regulations, Policies and Other Written Materials

The Department of Human Services (DHS) administers the state's Medicaid and State Children's Health Insurance Program (SCHIP), the Medical Assistance Program (MAP).[17] There is no state statutory or regulatory provision that requires or prohibits the collection of race, ethnicity, or primary language data. However, the application for both Medicaid and SCHIP benefits requests information on "Racial/Ethnic Heritage" and provides the following options: White, Black,

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[12] Or. Code § 30.670.

[13] *Thompson v. IDS Life Ins. Co.*, 274 Or. 649, 656, 549 P.2d 510, 513-14 (1976). The court reasoned that the more specific non-discrimination provisions of the insurance statutes controlled over the more general public accommodations statute.

[14] Or. Code § 743.804(10). However, all insurance policies contain a provision that subscribers, by acceptance of the benefits in the policy, are deemed to have consented to the examination of their medical records for purposes of the insurer's utilization review, quality assurance and peer review programs. Or. Code § 743.809.

[15] Or. Code § 746.600 *et seq.*

[16] Or. Code § 192.502. Information submitted to a public body in confidence and not otherwise required by law to be submitted is explicitly protected. This would seem to cover race and ethnicity data voluntarily given to or for the benefit of an a state agency.

[17] Or. Code § 411/060; Or. Admin. Rule 410-120-000. MAP encompasses Medicaid services, including the Oregon Health Program (OHP) demonstration project, and the SCHIP. Although DHS' Office of Medical Assistance Programs (OMAP) coordinates the MAP program, the Adult and Family Services Division (AFSD) determines eligibility for the OHP. *See* http://www.omap.hr.state.or.us and http://www.afs.hr.state.or.us.

Hispanic, American Indian/Alaska Native, Asian or Pacific Islander, or Other.[18] This form makes it clear that giving the information is voluntary.

The application contains a second question inquiring whether any applicant is an American Indian/Native American, presumably to determine if they qualify for the Indian health program.[19] The form also asks if the applicant speaks or reads English, and if not, which language s/he speaks and whether an interpreter is needed. [20] The information gathered from the forms is reported on the OMAP website, which offers monthly demographic breakdowns for eligible persons by race.[21]

There are several provisions addressing the cultural and linguistic needs of the enrollees in prepaid health plans[22] or HMOs. Although they do not have specific racial or ethnic data collection and reporting requirements, the plans must have written procedures and criteria for the health education of their beneficiaries, and must provide the information in a "culturally sensitive manner in order to communicate most effectively with individuals from non-dominant cultures."[23] Moreover, they must also provide information on how to access interpreter services to those in need of such services.[24]

PHPs additionally must have an access plan that, among other requirements, identifies populations in need of interpreter services.[25] The provision of care and interpreter services must be "culturally appropriate, i.e., demonstrating both awareness for and sensitivity to cultural differences and similarities and the effect of those on the medical care of the [Medicaid] member."[26] Similar provisions apply to Primary Care Case Managers (PCCMs),[27] another form of delivery mechanism

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[18] Interestingly, the application explains that the information helps the state follow Title VI of the Civil Rights Act of 1964, which allows them to ask for this information. *See* OHP Application at: http://www.omap.hr.state.or.us/omapforms/ohp7210web.pdf. (Question 5)

[19] *Id.*

[20] *Id.*

[21] *See* "OHP Demographic Reports" 1999, at: http://www/omap.hr.state.or.us/demographics/history/eligibles1999.pdf.

[22] PHPs are managed health, dental or mental health care organizations that contract with OMAP on a case managed, prepaid, capitated basis under the OHP. Or. Admin. Rule 410-141-0000(77).

[23] Or. Admin. Rule 410-141-0300(4); *see also* Oregon Medicaid Managed Care RFA ("Oregon RFA"), § 9.2.

[24] *Id.* at 410-141-0300(3)(I).

[25] *Id.*

[26] *Id.* at 410-141-0220(7)(c).

[27] PCCMs include hospital primary care clinics, rural health clinics, migrant and community health clinics, federally qualified health centers, county health departments, Indian or Tribal health clinics, physicians, nurse practitioners, physician assistants, and naturopaths. Or. Admin. Rule 410-141-0000(80).

utilized by Medicaid and SCHIP.[28] PCCMs "are expected to have a plan to access qualified interpreters who can interpret in the primary language of each substantial population of non-English speaking PCCM members."[29] Similarly, the Oregon RFA requires a PHP to "have appropriate written information (including . . . the member handbook . . . and information about complaints and hearings) in the primary language of each substantial population of non-English speaking OMAP members enrolled with the PHP."[30]

Within DHS is the Office for Oregon Health Plan Policy and Research (OHPPR), which collects and reports race-based demographic data for developing and evaluating statewide health policy.[31] Within it is the Oregon Health Council, which serves as the policy-making body responsible for health planning, and which must be representative of the linguistic and racial population of the state.[32]

The Oregon Health Division, also a part of DHS, collects racial and ethnic data in conjunction with vital statistics,[33] such as birth, death and marriage records,[34] as well as for public health purposes, including the tracking of communicable diseases, immunization records,[35] suicide attempts of minors,[36] and HIV test records.[37]

b. Discrimination

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[28] Or. Admin. Rule 410-141-0760(1).

[29] *Id.* at 410-141-0760(12) & (13). A "substantial population" is defined as: 35 non-English speaking households enrolled with the PCCM which have the same language.

[30] Oregon RFA, § 8.4.

[31] *See e.g.*, "The Uninsured in Oregon 1998," at: http://www.ohppr.state.or.us.docs/pdf/Uninsured%201998.pdf. Or. Code § 442.120(8).

[32] Or. Code § 442.035.

[33] Or. Admin. Rule 166-113-0020(8). *See also* Or. Admin. Rule 333-018-0030(3), which requires health care providers to report to local health departments the race of an individual if s/he falls within certain categories.

[34] Or. Admin. Rule 166-113-0030. Although the collection of birth records and paternity affidavits do not specifically require the race or ethnicity of the parents, the death records mention the voluntary collection of that information. *Id.* at 166-133-0030(4). *See e.g.* "Demographic Characteristics 1993-1999,"for births at: http://www.ohd.hr.state.or.us/chs/teen/410/99/sta/1999s.htm.

[35] Or Admin. Rule 166-113-0020.

[36] Or. Code § 441.750

[37] *Id.* at 166-113-0020(8); *see also* Or. Admin. Rule 333-018-0030(3) which requires health care providers to report to local health department the race of the individual if s/he falls within certain categories.

DHS and OMAP are required to ensure compliance with Title VI of the Civil Rights Act of 1964 and federal civil rights regulations prohibiting discrimination on the basis of race, color, or national origin.[38] There is a similar anti-discrimination provision for the AFSD.[39]

c. Confidentiality

DHS cannot disclose or use the contents of any records, papers, files, or communications of Medicaid or SCHIP participants for purposes other than those directly connected to the administration of the programs. Such information is considered confidential and privileged, except for child support or law enforcement purposes.[40] The same exemptions protecting medical and personal information from the general public records requirements apply to DHS.[41]

D. Observations

Oregon has no statutes or regulations requiring or prohibiting the collection of race, ethnicity or primary language data by health insurers.

In an attempt to provide universal health coverage for all Oregonians, Oregon is one of the few states that covers childless adults in its state Medicaid program (up to 100% of the federal poverty level).[42] Oregon has recognized the importance of addressing perceived health disparities for racial and ethnic minority groups, and has established the Governor's Racial and Ethnic Health Task Force,[43] as well as the Oregon Progress Board.[44] Because it has made a commitment to

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[38] Or. Admin. Rule 410-030-0010; *see also* Or. Code §409.040 and Or. Admin. Rule 410-120-1380(1)(c).

[39] Or. Admin. Rule 461-002-0525.

[40] Or. Code §411.320. There is also a confidentiality protection for information contained on enrollment applications for the Family Health Insurance Assistance Program. Or. Code § 653.830.

[41] Or. Code § 192.502.

[42] Conversation with Bob DiPrete, Executive Director, Oregon Health Council on 2/14/01. The Oregon Health Plan relies heavily on "prioritization of health services and managed care to achieve the public policy objectives of access, cost containment, efficacy, and cost effectiveness in the allocation of health resources." Or Admin. Rule 410-141-000(69).

[43] Created in 1999, the Task Force's purpose was to review, analyze and recommend changes as needed for state agencies to improve the individual and community health status for people of color and ethnic populations. *See also* Governor's Racial & Ethnic Health Task Force, "Final Report," (November, 2000) at: http://www.ohd.hr.state.or.us/omh/tf2000.html.

[44] The Board is an independent state planning agency responsible for implementing the state's 20-year strategic plan, Oregon Shines. Its membership reflects the state's social, ethnic and political diversity. *See* "Oregon Update: Oregon Minorities - A Summary of Changes in Oregon Benchmarks by Race and Ethnicity 1990-1998." (July 2000) at:

collecting race, ethnicity and primary language data, reducing its uninsured population, and improving cultural and linguistic access to its health programs, Oregon's managed care model could provide valuable lessons to guide other states exploring such efforts.

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http://www.econ.state.or.us/opb/minorities98.pdf; and "2000 Oregon Population Survey - Summary of Findings," (January 12, 2001) at: http://www.oea.das.state.or.us/ops2000/ops2000_report.pdf.