Speaker Rayfield,

In June 2022, the U.S. Supreme Court issued a ruling in *Dobbs v. Jackson Women's Health Organization* to overturn the federal constitutional right to abortion. The ruling unraveled 50 years of precedent and opened the floodgates for states to criminalize abortion, as well as put other fundamental rights at risk. As of November 2022, 12 states have passed bans on abortion. Recent data shows there are now 22 million women of reproductive age who have virtually no abortion option in their state. Furthermore, US Senator Lindsey Graham in September introduced legislation to create a federal ban on abortion.

These bans hurt real people who should have the freedom to make their own decisions. People, not politicians, should have the right to make their own decisions, including when it comes to abortion care. But many Americans are facing a reality in which people will face jail time for seeking an abortion, along with the doctors, nurses and other providers who provide that care.

Overturning *Roe v. Wade* has worsened the public health crisis around abortion. The race to criminalize access to health care will deepen health inequities and create generational consequences. We anticipate the ruling to overturn *Roe* will create a domino effect, emboldening those who wish to restrict access to birth control and other critical forms of health care. Banning abortion is part of a wider effort to control individuals' bodies and lives. State lawmakers across the U.S. have also introduced a record-breaking number of anti-LGBTQ bills, including actions to prevent access to lifesaving health care for trans and non-binary Oregonians.

Even before the *Dobbs* decision, there were many barriers for individuals to access reproductive health care services. Overturning *Roe v. Wade* means the number of people facing obstacles to get the essential health care they need will skyrocket. It means that Black, Latino and Indigenous people, immigrants, people living with low incomes, trans and non-binary people, and people in rural areas — communities who have long faced barriers to abortion access — will face greater challenges.

Thanks to decades of advocacy and legislative action, Oregonians have the right to an abortion without government interference. Oregonians have protected this right time and again at the ballot. And yet, despite Oregon's nationally recognized leadership in protecting the right to health care, barriers to accessing care still exist in our state.

There are too many Oregonians who must travel over 300 miles across the state to find a provider, fight with insurance about whether necessary services are covered, or face hostility while walking into a health center. As more abortion bans go into effect across the nation, we need to reduce barriers so that everyone who relies on Oregon for reproductive health care can get the services they need.

Leadership at all levels of the government is needed now more than ever to protect access to care.

At your request, community and advocacy organizations, providers, clinic administrators, and issue experts came together over the last few months to form the Reproductive Health and Access to Care (RHAC) workgroup. Our goal was to identify how Oregon can protect, strengthen, and expand equitable access to reproductive health care and other services that have been under attack at the state and federal levels. Personal medical decisions must be protected from government interference.

We want to thank the workgroup participants who spent numerous hours with us and shared their expertise. The following report summarizes our recommendations for a blueprint for how the Legislature and executive branch can take steps to protect and ensure access to health care in Oregon.

Respectfully,

The RHAC Planning Team

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EXECUTIVE SUMMARY

In response to the leak of the *Dobbs v. Jackson Women's Health Organization* decision in May 2022, Speaker Rayfield convened a workgroup to develop recommendations that will protect and expand access to health care services that are at risk in a post-*Roe* world. This workgroup identified barriers for patients seeking care, the challenges healthcare providers and facilities face delivering care, and the potential legal issues patients and providers may face. Based on these findings, the workgroup made comprehensive recommendations to protect against the criminalization of health care and close existing health care access gaps in the state. Over 80 individuals representing health care providers, clinics, advocates, national experts, policymakers, and community organizations met across three subcommittees. Below are our recommendations:

- Invest in patient and consumer education and outreach
- Ensure compliance with existing coverage requirements and enhance network adequacy standards
- Close gaps in insurance coverage
- Enhance access to care in medically underserved regions of the state
- Ensure the sustainability of care through adequate reimbursement rates
- Reduce administrative barriers to help providers deliver care
- Build up the health care workforce and expand opportunities for continued learning
- Protect individuals located in Oregon from criminal and civil liability for receiving, supporting, or providing reproductive and gender-affirming care
- Prevent interference with health care clinics and providers
- Protect Oregonians from misleading and biased medical claims by crisis pregnancy centers
- Support compliance with existing sexuality education laws and standards
- Protect the privacy of individuals who receive, support, or provide reproductive and gender-affirming care
- Expand existing rights to access health services

TERMINOLOGY

Term	Definition
Abortion	Termination of a pregnancy.
Abortion Funds	This term commonly refers to a network of non-profit and other community aid organizations that seek to reduce financial barriers for all people capable of becoming pregnant. They may assist with logistics coordination and other non-financial support to ensure medically appropriate care is available to those who determine they need it.
Cisgender	When a person's assigned sex and gender identity are the same.
Commercial Plans	A term used to describe health insurance plans purchased on the exchange regulated by the Department of Consumer and Business Services' Division of Financial Regulation.
Comprehensive Sex Education	Programs that include information and skill-building around sexuality, birth control, STD prevention, abstinence, healthy relationships and consent, sexual orientation/gender identity, etc. Comprehensive sex education is sex-positive, inclusive, medically accurate, trauma-informed, evidence-informed, and developmentally appropriate.
Contraceptive	Any behavior, device, medication, or procedure used to prevent pregnancy. Also known as birth control.
ERISA	A federal law named the Employee Retirement Income Security Act (1974). Nationally, ERISA regulates 2.4 million health plans (and retirement and welfare benefit plans). ERISA preempts most state law in an effort to standardize employer benefits (read more here). Administrative changes that do not impact health benefits (such as consumer information and requirements) may be free from preemption (where federal law trumps state law).
Federally Qualified Health Centers (FQHCs)	Federally Qualified Health Centers are federally certified clinics, centers, practices, and other types of organizations that care for Oregon's most vulnerable (homeless, low-income folks, migrant communities, etc.). FQHC refers to the reimbursement status in exchange for requirements of service – FQHCs are federally funded and impacted by federal funding exclusions. Read more about FQHCs, who they serve, and family planning here.
Gender Identity	How a person expresses and identifies their sense of gender.
Gender-Affirming Care (GAC)	Comprises social, psychological, behavioral, and medical interventions to support and affirm an individual's gender identity when it conflicts with the gender they were assigned at birth. The interventions in practice help transgender and nonbinary people align various aspects of their lives with their gender identity. Gender-affirming care is recognized as medically necessary by major national, professional, and global health care organizations, and research has demonstrated it is a life-saving intervention.
Health Evidence Review	The Health Evidence Review Commission reviews procedures and coverage benefits for the Oregon Health Plan (OHP) to determine medical

Commission (HERC)	efficacy and preferences and develops the "prioritized list of health services" that informs the OHP benefit.
Herfindahl-Hirschman Index	A economic measurement of market concentration that is useful when measuring the health insurance market in Oregon.
Hyde Amendment	Refers to the Hyde Amendment that restricts federal funding on abortion. Hyde-impacted clinics, providers, and facilities must often separate funds and pursue non-federal funds to provide services that are barred by the Hyde amendment. See FAQ here.
Indian Health Services (IHS)	An agency within the federal Department of Health and Human Services (HHS). Indian Health Services (IHS) is the primary federal health care provider for American Indians and Alaska Natives. Learn more here. IHS is affected by the Hyde amendment.
Medication Abortion	Available since 2000, when FDA approved the use of mifepristone. Can be pursued in clinical settings or at home; most safe during the first trimester.
Non-Medical Exemption	Refers to exemptions that may be claimed due to a conscience clause laws. Applies to individual providers of care, employers, and facilities. The impact on people seeking care is typically a refusal of service or lack of health care coverage if covered by a plan affiliated with an institution that claims an exemption.
Oregon Health Plan (OHP or Medicaid)	The Oregon Health Plan (OHP) is the state's Medicaid program. The plan covers 1.4 million Oregonians and is offered mostly at no-cost to the enrollee. The plan covers children up to 300% of the federal poverty level [FPL] and adults up to 138% FPL (a calculation of household income).
Pregnant People	All people capable of becoming pregnant regardless of gender identity. Unless where source data specifies its use, this report uses gender neutral terms to accurately describe who may experience pregnancy.
Prior Authorization	A process that requires pre-approval for insurance billing for select covered health care services.
Reproductive Health Equity Act (RHEA)	HB 3391 (2017) provides expanded coverage for some Oregonians to access free reproductive health services, especially those who, in the past, may have not been eligible for coverage of these services. It also provides protections for the continuation of reproductive health services with no cost sharing, such as co-pays or payments toward deductibles, and prohibits discrimination in the provision of reproductive health services.
Reproductive Health Program (RH)	The RH Program administers several key programs, including the Title X federal grant and the 1115 family planning Medicaid waiver, Oregon Contraceptive Care (CCare), both of which have extensive administrative requirements for participating clinics. The program also provides funding for planning, infrastructure, and maintenance grants for RH Program-certified clinics to meet these administrative requirements.
TRICARE	A federal health insurance program for US military service members, retirees, and their families. TRICARE is affected by the Hyde amendment.

THE STATE OF THE STATE

Time and again, Oregonians have affirmed their support for making abortion safe and accessible to all. This state has long valued the right to bodily autonomy and to choose if and when to start a family. Abortion remains legal in Oregon due to decades of advocacy, organizing, and proactive legislation.

Oregon's History of Protecting Medical Care

Oregon has a long history of protecting the health care decisions that many states are now criminalizing. Oregon first legalized abortion in 1969, three years before Roe, and Oregon voters have defeated six anti-abortion ballot measures since 1973.

In 2007, the Oregon Legislature passed SB 2, the Oregon Equality Act. This landmark legislation prohibited discrimination based on sexual orientation and gender identity in employment, housing, public accommodations, and other categories.

In 2012, the Department of Consumer and Business Services (DCBS) clarified that an insurer may not discriminate on the basis of an enrollee's actual or perceived gender identity or on the basis that the enrollee or prospective enrollee is a transgender person.

In 2013, the Centers for Disease Control and Prevention (CDC) recommended prescribing up to one year of contraception after studies found that year-long dispensing increased adherence to the contraceptive regimen, reducing the risk of unintended pregnancy. The Oregon Legislature acted to pass HB 3343 in 2015, requiring commercial insurers to cover 12 months of contraception after an initial period. When used continuously, contraception can be 99% effective against unintended pregnancy.[i] That same year, the Legislature also passed HB 2879, expanding access to care by allowing pharmacist to prescribe contraception.

In 2016, DCBS published a bulletin making it clear that insurers could not discriminate in coverage based on a member's gender identity, requiring that if a procedure was covered for a cisgender individual, that same procedure must also be covered for transgender individuals and could not be denied based on gender identity.

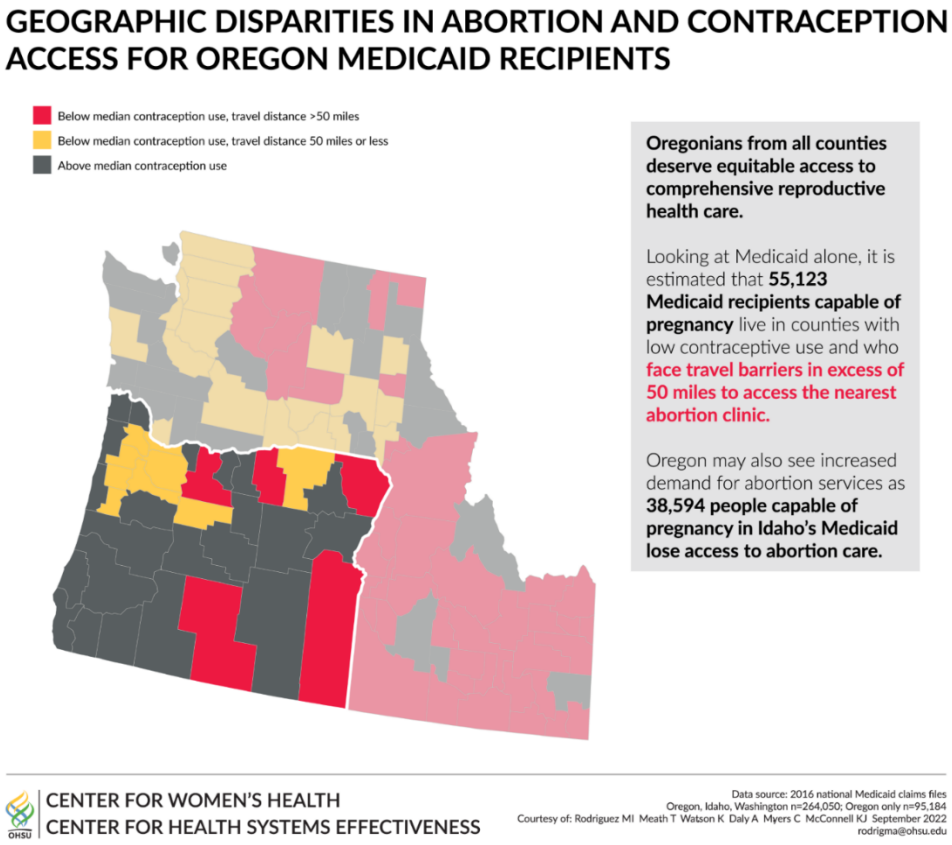
In 2017, Oregon legislative leaders and advocates predicted long-term threats to abortion access and led passage of the Reproductive Health Equity Act (RHEA). This first-in-the-nation law codifies in statute the right to an abortion and expands family planning and postpartum care in the state. The landmark legislation also strengthened laws protecting patients from discrimination based on gender identity.

In 2019, the Oregon Legislature passed SB 250, which aligned key provisions of the Affordable Care Act with the Oregon law, further protecting Oregonians from health benefit discrimination

on the basis of actual or perceived race, color, national origin, sex, sexual orientation, gender identity, age, or disability.

In 2021, the Oregon Legislature passed new regulations ensuring that the public's interest is preserved when mergers and acquisitions of major health care facilities and insurers occur. This law was especially important given 52 of the 59 hospitals who report to the Oregon Health Authority through the Hospital Reporting Program had a high Herfindahl-Hirschman Index (HHI), demonstrating highly concentrated markets and monopolies in regions of Oregon. Hospitals that may claim non-medical exemptions to providing reproductive health services are found in Ontario, Baker City, Pendleton, Hood River, Milwaukie, Newberg, Portland, Medford, Cottage Grove, Springfield, Florence, Tillamook, and Seaside.[ii] Oregonians may be limited in the type of medical care they can receive in these facilities, which represent approximately 30% of all hospital beds in Oregon.[iii]

Figure 1: Geographic Disparities in Abortion and Contraception Access for Oregon Medicaid Recipients



In March 2022, Democratic leadership seeded the Reproductive Health Equity Fund to mitigate harm from the looming Supreme Court decision, address urgent patient needs for abortion funds and practical support – like travel and lodging – and to expand provider network capacity following the then-anticipated ruling.

Access to Abortion in Oregon in 2022

While our work in this state must be applauded, legislative leadership cannot become complacent. Existing gaps in access to care require immediate remedy and the threat of criminalizing health care choices only grows. Oregon's reality is simple: nearly one in four women will have an abortion by the age of 45 and Oregonians across the state have unequal access to reliable forms of health care.[iv] Three quarters of Oregon counties do not have an

abortion provider (see Appendix 2). Safety net services providing sexual health and STI/STD screenings, pap smears, and basic cancer screenings have declined over the years.

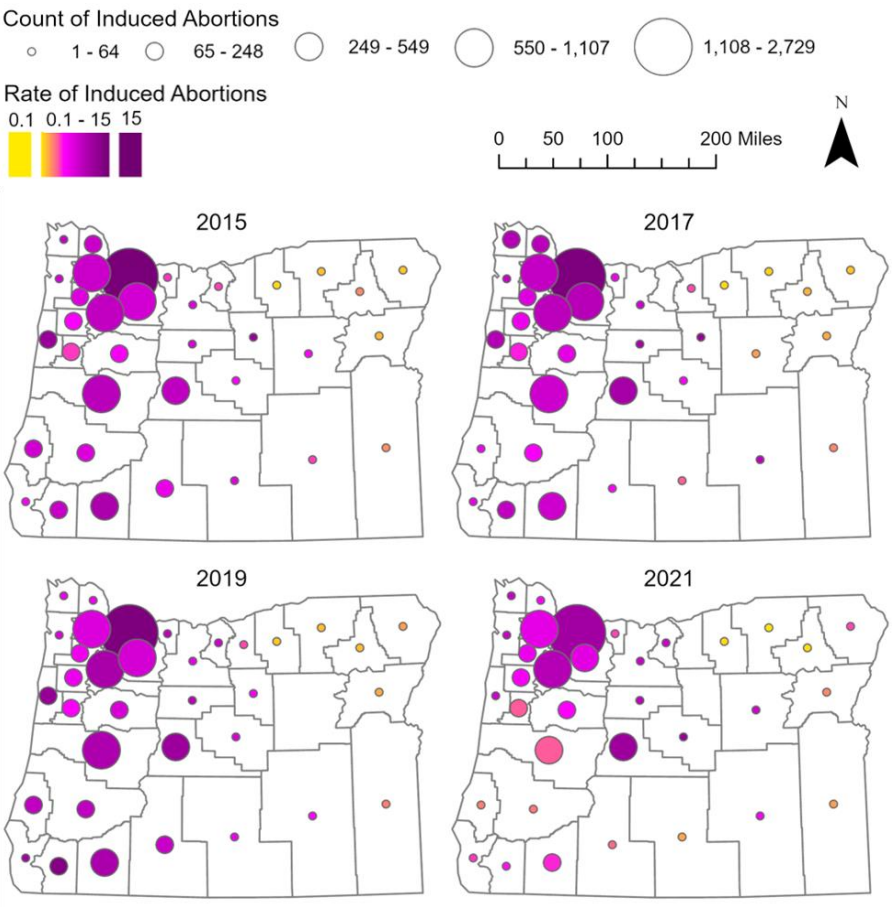
An analysis conducted in 2017 found that 20% of people seeking abortion care must travel for services.[v] Many Oregonians have and will continue to travel over 350 miles for abortion care. Access to reproductive options is the most limited where contraceptive use is the lowest (see Figure 1). Coverage gaps remain for medically necessary treatment. Benefits navigation is limited, and there are administrative barriers and delays to timely care even for Oregonians who know where to look.

Eastern Oregonians who relied on Idaho cities like Boise and Meridian as their closest health centers could see an up to 35% decrease in access to care now that the state's near total abortion ban has gone into effect.[vi] According to the Guttmacher Institute, Oregon could experience a potential 234% increase in people traveling to the state depending upon the bans that go into effect, creating added barriers for people seeking abortion care locally (see Figure 2).

***Figure 2*. Access to Health Care is a Statewide Issue: Count and Rate of Induced Abortions by County of Residence 2015 – 2021**

Source: Legislative Policy and Research Office

Data: Induced abortion data from [Oregon Health Authority Vital Statistics](). The number of women is based on Census American Community Survey (ACS) 5-year data, table B01001 2016-2020. Notes: Data includes only induced abortions that occurred in Oregon for residents of Oregon. Data for 2021 is preliminary and should not be used for statistical analysis. The count represents the number of residents of that county that received an abortion in Oregon that year. The rate represents the number of induced abortions per 1,000 women aged 15–44.



When considering these factors, we know that low-income, rural, and BIPOC Oregonians stand to lose the most. Travel time, lost wages, benefit navigation mazes, lack of available information,

care deserts, stigma, and rampant politicization all disproportionately impact communities of color, low-income communities, and communities outside of the I-5 corridor.

Providers report that we are already seeing the effects of other states' actions to criminalize abortion. They also report that incidences of harassment of medical providers is on the rise. And nationally, the fall of *Roe* has given new moment to a movement with a long-term goal of banning abortion across the U.S. This is the new reality we must prepare for in a post-*Roe* world.

There were also a record numbers of bills in 2021 and 2022 attacking LGTBQ rights and healthcare access.[vii] The healthcare landscape post-*Roe* raises innumerable questions about access to gender-affirming care and other life-saving healthcare treatments.

In line with Oregon's long history of protecting access to health care decisions, leaders must be proactive to ensure that the criminalization of health care never happens here. The state has done critical work in recent years on these issues and much is left to do. We are pleased to offer the recommendations in the report for your consideration.

RECOMMENDATIONS

Invest in patient and consumer education and outreach

While clinics and health systems may have health navigators available to support patients, communities with limited access to information, language or cultural barriers may be better served by trusted community messengers. Online provider directories can contain outdated, or inaccurate information, potentially misrepresenting the total number of providers available (ghost networks) and making it difficult for enrollees to locate in-network providers. Enrollee insurance handbooks can also be arcane and/or inaccessible, making it difficult for enrollees to recognize the full scope of reproductive health benefits available to them. Some advocacy and service organizations have compiled provider directories, referral lists, and other trusted, verified information that is determined safe by their community. This work is an important piece of how Oregonians access care.

- Develop and fund community health worker curriculum that include information about reproductive health and the state's reproductive health programs. Community health workers are specialists that help patients navigate the health care system and provide non-clinical support. Community health workers are trusted community members and/or have strong cultural understandings of the communities that they serve.
- Expand existing Oregon Health Authority and Department of Human Services contracts with community-based organizations to support culturally specific consumer navigation

and community education about reproductive health, using criteria developed in partnership with community-based organizations and reproductive health partners.

- Fund one or more organizations to maintain centralized webpages for reproductive health care and gender-affirming care resources in Oregon. Include regional information where possible. See Abortion is Healthcare for a model.
- Invest in an overdue and collaborative education campaign to educate consumers and providers about their rights under Oregon law. Misinformation and lack of information about what consumers are entitled to under Oregon law are pervasive at the patient and provider levels. Licensing boards, agencies, associations, and advocacy groups should work collaboratively to ensure the public is informed of their legal rights, mandated covered services, including the 12-month dispensing of contraceptives, and where to go for more information.
- Update state webpages to include easily searchable, useable information about their programs and state laws. The Oregon Health Authority and Department of Consumer Services must update their web pages with usability in mind. The state should amplify community resources, not duplicate them. Agencies can look to Washington's Department of Health as a model.

Ensure compliance with existing coverage requirements and enhance network adequacy standards

Oregon's network adequacy law does not establish specific quantitative standards for evaluating whether an insurer's provider network is adequate for enrollees. Instead, Oregon's existing network adequacy rules require insurers to demonstrate compliance with national standards or through a factor-based evaluation. The current standards can be vague and may not be sufficient to evaluate meaningful access to all services covered under Oregon law. These factors often present consumers with a maze of outdated and incomplete information indicating that the information currently available to enrollees is inadequate.

- Apply Oregon's network adequacy statute (ORS 743B.505) to large group plans.
- Add quantitative network adequacy standards at least as stringent as federal requirements (e.g., time, distance, appointment wait times, availability standards, and provider-to-enrollee ratios) with specific and demonstrable adequacy for reproductive and gender-affirming health care to existing law. Adopted standards should adequately account for the flexibility of telehealth to fill network adequacy gaps.
- Provide enforcement authority to DCBS for network adequacy standards.
- Ensure network adequacy standards account for the reality of access for Oregonians who have diverse language, mobility, disability, and technology needs.
- Adopt a proactive approach to enforcement of coverage mandates instead of relying on consumer complaints to drive audits or examination of mandated services. DCBS' recent actions to examine compliance with the Reproductive Health Equity Act should be

applauded. The Oregon Health Authority should similarly examine access to care for covered benefits under the Oregon Health Plan.

- Explore ways to improve complaint pathways to allow providers and navigators to more easily submit complaints on behalf of enrollees and share challenges faced by enrollees in accessing care.

Close gaps in insurance coverage

Despite Oregon's record rate of insurance coverage, not all Oregonians have the coverage they need for sexual and reproductive health. The current system of coverage is fragmented, resulting in subsets of Oregon's population who do not have comprehensive reproductive health care. Further, coverage of medically necessary gender-affirming care varies by insurance type, and Oregon does not currently cover all health services for transgender and non-binary Oregonians.

- Grant the Oregon Health Authority the authority and funding to provide options for those without abortion coverage, also known as the "coverage doughnut." Strategies for expanding coverage could include expanding existing programs, the use of a third-party administrator for reimbursement and other market products, and/or creation of additional program funds. The coverage doughnut includes uninsured Oregonians, people enrolled in certain health benefit plans, including self-funded group plans where the employer chooses to opt out of providing abortion coverage, those covered by federal programs, such as Indian Health Services, TRICARE, Veterans Affairs, health plans for federal employees (per federal Hyde Amendment restrictions), and people covered by health plans exempt from the Reproductive Health Equity Act who may be without comprehensive reproductive health care coverage.
- Greater coordination of abortion funds is needed in Oregon to ensure a seamless experience for consumers. Some clinics may have billing systems or policies that cannot receive third-party payments (abortion funds) leaving patients to rely on uncompensated care funds, if the clinic or health system has made this resource available, or pay out of pocket and seek reimbursement if learning of this limitation at the time of care.
- Continue to integrate and fund practical patient support, such as childcare, travel, doula support, lost wages, and seek ways to remove other barriers to accessing timely care.
- Close the local government loophole and explicitly apply RHEA and 12-month contraceptive coverage to all public employee health benefit plans.
- Ensure that commercial insurers and the Oregon Health Plan cover all medically necessary gender-affirming care (GAC) services. OHP started covering some, but not all, GAC services on January 1, 2015. The 2016 DCBS bulletin does not address the gap in coverage for the full range of medically necessary procedures unique to the needs of transgender and gender nonconforming Oregonians. These gaps in coverage for GAC services still vary widely by insurance plan, creating significant barriers to coverage for the full range of medically necessary services.

- Amend Oregon's 12-month coverage law to apply to the Oregon Health Plan (OHP). In 2013, the CDC recommended prescribing up to one year of contraception after studies found that year-long dispensing increased adherence to the contraceptive regimen, reducing the risk for unplanned pregnancy. In 2015, the Legislature passed HB 3343, allowing 12 months of contraception to be covered after an initial period. This law does not apply to OHP, though many coordinated care organizations allow 12-month supplies, and fee-for-service elected to adopt this practice as well. The Oregon Health Authority intends to adopt rules and make changes to the Medicaid billing system to allow for 12-month coverage. The Legislature should codify this practice by amending existing law to include Medicaid plans.
- Pharmacies dispense what is prescribed, and many prescribers and patients still do not know that 12-month coverage is covered and encouraged under Oregon law. Twelve-month prescribing should be the rule, not the exception. The state should fund a collaborative education campaign to ensure all providers, carriers, pharmacists, and people in need of contraception are aware of the contraception benefits required under Oregon law.

Enhance access to care in medically underserved regions of the state

Federally qualified health centers (FQHCs) and other safety-net clinics are essential to fill rural and coastal service gaps and they serve Oregon's most vulnerable. However, FQHCs are impacted by the Hyde amendment due to federal grant funding. For many low-income Oregonians, local public health clinics serve as the primary or only source of care. Services may include core behavioral health, substance and harm reduction, physical health, nutrition, and sexual health screenings including STD and STI testing. Capacity for basic reproductive health services varies throughout the state throughout these networks.

- The Oregon Health Authority should partner with associations to create legal and technical guidance. The complexity and intermingling of federal grant funding may lead to hesitation to offer referrals and other services not excluded through federal funding prohibitions.
- Implement a regionally diverse pilot for FQHCs interested in expanding reproductive health services to support abortion access through state funding. Establish a technical advisory group to assist with pilot design and administration. Pilot criteria must be flexible to permit the use of mobile clinics or other temporary or transitional features, and applicants must demonstrate a governance commitment to expanding reproductive health services.
- Develop robust support systems for clinics certified with the Oregon Health Authority's Reproductive Health (RH) Program or programs who would be eligible to participate.
- Allocate funds to the RH Program to provide direct or third party contracted training and technical support to certified clinics to assure compliance with requirements.

- Allocate funds to support county public health infrastructure.
- Build and invest in expertise to support cross-county collaboration, shared services agreements, and other resources (like providing a safe and secure place to access telehealth). Broader healthcare workforce issues also hamper local public health authorities (LPHAs) and FQHCs. LPHAs have the unique challenge of hiring at a county pay scale, and staff working in clinics in rural Oregon may face additional housing and childcare needs. State resources can support and sustain cross-county collaboration.
- University and community college health centers fill a necessary role in Oregon's health care network. These clinics are often located on-campus and are spread throughout the state. Following models by California and Massachusetts, the legislature should explore opportunities to expand access to emergency contraception and medication abortion for students and the community.

Ensure the sustainability of care through adequate reimbursement rates

Inadequate OHP and Reproductive Health Program reimbursement rates hinder access to care. The state has a long, voter-approved history of supporting access to health care with taxpayer dollars. Reimbursement rates should echo this value and include the direct, non-clinical costs of providing abortion care.

- Create a telemedicine medication abortion rate for OHP fee-for-service/Open Card and the RH Program. Additional state funds may be necessary to support this work. Rates should be comprehensive to include direct costs such as shipping.
- Establish and maintain uniform and adequate reimbursement rates for sexual and reproductive care across state programs. Current reimbursement rates differ across state programs.

- Remove barriers to doula certification. Doula certification requires in-person contact hours. Contact hours may be uncompensated, and for doulas in non-metro areas, travel distance to contact visits creates additional barriers to obtaining certification and Medicaid reimbursement. Doulas bridge cultural differences and provide evidence-based services that address racial disparities in care. Doulas provide patient-centered, non-clinical support to pregnant Oregonians. These barriers can be particularly acute for historically disadvantaged Oregonians interested in serving medically underserved communities and barriers to certification limit access to doula services for Medicaid enrollees. The Oregon Health Authority recently pursued an increase to doula bundled services under the Oregon Health Plan. Making certification more accessible can allow greater access to increased funding opportunities.

Reduce administrative barriers to help providers deliver care

The current legal landscape around the country is quickly changing, leaving providers and health clinics in an uncertain time. Despite solid legal protections for health services in Oregon, a criminal or civil charge from another state could have consequences on an Oregon provider's ability to deliver care.

- Prohibit a medical malpractice insurer from taking any adverse action. This should include but be not limited to denial or revocation or coverage, sanctions, fines, penalties, or rate increases against a health care provider or health insurance purchaser if based solely on a covered provider providing, authorizing, recommending, aiding, assisting, referring, or otherwise participating in an abortion or other health service provided for an abortion, or gender-affirming care if provided in a manner consistent with Oregon law.
- Prevent adverse action by a licensing board against a health care practitioner solely based on the provision of reproductive health care or gender-affirming care that is legal in Oregon but violates another state's law, with exceptions for unprofessional conduct, negligence, and malpractice. Doing so will provide necessary assurance for providers in Oregon. While Oregon is not a compact state and is not beholden to automatic information sharing or revocation caused by another state's action, the state can take proactive steps to ensure this is not a possibility in the future, including removing the automatic license suspension under ORS 677 if incarceration in another state is due to providing medical care in accordance with the standard above.
- Establish an advisory group within the Oregon Health Authority with providers and payers to remedy inconsistent billing practices, denials, and utilization policies across state-funded programs. Inconsistent coding practices affecting reimbursement and dispending guidance across CCOs is confusing.

Build up the health care workforce and expand opportunities for continued learning

The state has a role to ensure care team integration and cross-team education about abortion services. Misconceptions about who gets an abortion, how frequently they occur, and the legality of care in Oregon must be remedied. Providers and care teams who do not provide abortion services will interact with patients who have terminated a pregnancy through follow-up care, counseling, pediatrics, and more.

- Fund centers of learning that are stepping up to increase full spectrum reproductive health care opportunities for out-of-state residents and fellows from anti-abortion states. The Legislature should not rely on philanthropy to fill this education gap.

- Increase state funding for existing provider incentive programs for those who commit to providing care to medically underserved communities. Many programs are oversubscribed, and additional sustained funding can support rural health care needs.
- Target state funding to improve entry to the health care workforce pipeline for BIPOC and medically underserved community members. Sustained investments are necessary to ensure the success and completion of health care workforce programs for historically underserved Oregonians.
- Incentivize the development of accredited continuing education programs (CEs) across provider types, including pharmacists. CEs should seek national accreditation where possible.

Protect individuals located in Oregon from criminal and civil liability for receiving, supporting, or providing reproductive and gender-affirming care

Numerous states are threatening to criminalize and file civil lawsuits against individuals who receive, support, or provide reproductive and gender-affirming care in Oregon. The laws in these states are creating a new and complicated legal landscape for providers and patients. To the degree possible, Oregon should protect individuals located in Oregon from facing liability in those states. Within Oregon, individuals who self-manage abortion face fewer risks for criminalization than in many other states, but some risks are still present. Oregon should clarify its laws to ensure that in-state prosecution related to abortion and pregnancy loss does not occur.

- Allocate funding for legal support individuals facing out-of-state civil liability for receiving, supporting, or providing legal healthcare in Oregon who may incur significant legal fees if faced with out-of-state criminal liability. There is insufficient legal support for individuals facing civil liability. Private and philanthropic legal defense funds have been set up to help such individuals. State funding can supplement existing legal defense programs.
- Codify in statute Governor Brown's commitment not to extradite non-fugitives for providing legal health care services in Oregon that are criminalized by other states. This would clarify that a future governor does not have the discretion to extradite individuals in these cases.
- Strengthen Reproductive Health Equity Act (RHEA) protections to explicitly prohibit prosecution in Oregon related to the termination of pregnancy, the experience of miscarriage, stillbirth, or other pregnancy loss, and those who help others obtain abortion care. Although Oregon codified the right to abortion in RHEA, the Act does not include an explicit prohibition on prosecution related to abortion. Adding this reference will reaffirm Oregon's commitment to this area.
- Amend and repeal statutes that have been utilized in other states to criminalize abortion, including antiquated laws that no longer serve a public safety purpose.

Prevent interference with health care clinics and providers

Harassment of providers and patients is increasing across the country, including in Oregon. Oregon law does not currently have sufficient protections against violence directed at providers, patients, and reproductive health service clinics. Washington state has enacted comprehensive laws to protect health care clinics and providers from harm and interference. This includes a criminal law (fines and/or misdemeanor charges), a civil action (for damages, attorney fees, and injunctive relief) that may be filed by a person or health care facility, and direction to the court to take steps in criminal and civil actions to safeguard individual privacy and prevent harassment of patients and providers (including granting protective orders).

- Enact criminal and civil remedies for interference with health care facilities tailored to comply with strong free speech provisions in the Oregon Constitution.

Protect Oregonians from misleading and biased medical claims by crisis pregnancy centers

Crisis Pregnancy Centers (CPCs) mislead women by frequently presenting themselves as medical facilities to draw in low-income and young people experiencing an unplanned pregnancy.[viii] Yet, most of the services they provide are not recognized by medical professionals as medical services.[ix] CPCs are also known to disseminate false and biased medical claims focused on stigmatizing abortion and contraception and promote made-up, abortion-related mental health conditions not recognized by medical experts. CPCs vastly outnumber abortion care clinics in Oregon (44 to 13).[x]

- Ensure full enforcement of Oregon's Unlawful Trade Practices Act (UTPA). CPCs who violate the UTPA should face enforcement actions. While some states have passed or are considering legislation specifically prohibiting deceptive advertising and practices by CPCs, Oregon's UTPA is already broad enough to cover such activities.
- Educate the public about the nature of CPCs, including information about how individuals can report deceptive advertising and practices. Many individuals do not understand the nature of CPCs, the limited scope of services they provide, and the fact that there are legal remedies for CPCs engaging in deceptive advertising and practices. Several other states have issued alerts and other forms of public education to ensure that individuals are fully informed.

Support compliance with existing sexuality education laws and standards

Oregon has strong educational standards that support the development of healthy relationships, reduce sexual violence and bullying, prevent unintended pregnancies and the transmission of sexually transmitted diseases and infections, and create supportive and inclusive environments. In 2021, 48% of school districts responded to a voluntary implementation survey. Out of those districts, only 64% stated having a written plan of instruction or comprehensive sex ed.[xi]

- Enhance state guidance, resource community partnerships, develop and implement e-curriculum, and clarify rules where needed to incentivize and support districts in meeting sexuality education laws and Division 22 standards.
- Strengthen verification of compliance with existing laws and rules.

Protect the privacy of individuals who receive, support, or provide reproductive and gender-affirming care

There are numerous ways the state may improve security and privacy protections for health care providers, patients, volunteers, and staff.

- Protect provider home addresses by expanding Oregon's Address Confidentiality Program under ORS 192.822 to reproductive and gender-affirming health care providers. This would allow providers who fear for their safety to obtain a substitute address.
- Amend ORS 677.320(1) to clarify that the Oregon Medical Board is obligated to notify district attorneys only when a Board investigation uncovers conduct for which a person may be subject to criminal prosecution in Oregon. This clarification would eliminate any ambiguity over whether the Board is required to report the provision of reproductive and gender-affirming health care to district attorneys in states where it may be considered illegal.
- Provide an exemption for reproductive and gender-affirming health care providers modeled after ORS 192.345(30), which provides a conditional public disclosure, or broaden ORS 192.368 to allow reproductive and gender-affirming health care providers to request non-disclosure of address, phone, and email.
- Amend ORS 676.177 to restrict disclosure of confidential information related to the provision of reproductive and gender-affirming health care to out-of-state licensing boards and law enforcement agencies.
- Prohibit Oregon judges from issuing subpoenas or summons for a civil or criminal violation of a law of another state involving reproductive and gender-affirming health care services that are legal in Oregon.

Expand existing rights to access health services

The Reproductive Health Equity Act (RHEA) codified the right to abortion in Oregon statute (ORS 659.880) by prohibiting government interference with an individual's choice to terminate a pregnancy. This right does not cover other decision about pregnancy, reproductive health care more broadly or gender-affirming care.

- Expand on RHEA's strong protections by prohibiting government interference with a larger range of protected health services.

Further analysis needed

The workgroup went through an immense amount of information in a short timeframe and identified the following issues as ones that need further evaluation to understand the causes of barriers, remedies for barriers, and implementation of potential remedies listed below. The following strategies and barriers require additional research:

- Doulas are still facing pandemic-related barriers to serving clients in hospital settings. Patients should have full access to their selected care teams.
- Expand exposure to miscarriage management, medication, and aspiration abortion throughout professional health programs by including information about patient experiences within their curriculum. Not all providers will perform an abortion or prescribe contraception, but many providers from various care teams may interact with a patient who has had an abortion or is experiencing a miscarriage and may be a part of a patient's care team following pregnancy loss.
- Oregon must continue to seek the most robust avenues to protect the freedoms we enjoy in the event that the U.S. Supreme Court attempts to overturn other landmark decisions that threaten the right to use contraception or marriage choices. Unlike other states, Oregon does not have a state constitutional right to abortion, legislation can be vetoed, and laws can change.
- Explore ways to expand consumer privacy protections, including restrictions on unnecessary sharing, sale, and collection of data that can be used to prosecute someone for an abortion. The Attorney General's consumer privacy task force will make recommendations for the 2023 legislative session.
- Oregon has extensive anti-discrimination laws, several of which relate to receipt of medical care. More research is needed to determine whether additional protections are needed in this area.
- Prevent the arrest and re-arrest of individuals who face out-of-state extradition due to warrants in other states related to supporting or providing legal health care in Oregon.

- Require mandatory release pending extradition when evidence is provided that an out-of-state arrest warrant is based on the criminalization of receiving, supporting, or providing legal health care in Oregon.
- Credentialing remains a significant administrative burden for providers and clinics. While well-intentioned, the Oregon Common Credentialing Program never got off the ground, and providers still face duplication and onerous processes to become credentialed. Lawmakers must revisit this problem and the work done in 2013 and 2015.
- The Legislature should support the ongoing work of the Health Licensing Office and Board of Electrologists and Body Art Practitioners to expand access to and the licensing of electrologists in Oregon.
- Individuals and families need accessible and affordable paths to decide how they build their families if they choose to do so. Fertility preservation is cost-prohibitive for many Oregonians, and some gender-affirming therapies and procedures may result in infertility.
- Increase patient utilization consistency among Coordinated Care Organizations (CCOs). CCOs maintain their preferred drug lists (PDLs), and their prior authorization (PA) criteria also differ. It is difficult to achieve aligned PA criteria without PDL alignment. Alignment of CCO and Fee for Service PDLs was proposed in House Bill 2678 (2019 Legislative Session) but was not passed. While some CCOs have updated prior authorization guidance, PA remains inconsistent across CCOs. Consumers face different criteria for the same service on the Oregon Health Plan (e.g., access to hormone treatment methods).
- A current challenge in patient access to care results from a disconnect between the validity of procedure letters and the availability of care authorized by the letters for some gender-affirming care procedures. Depending on the coverage, letters may expire 6 and 12 months from the date of issuance, while the care sought may not be available for 18 to 24 months.

APPENDIX A:

RHAC participants put in an immense amount of time and thought to make this document a reality. Below is a list of participating organizations.

All* Above All
APANO
Basic Rights Oregon
Cascade AIDS Project
Center for Reproductive Rights
Central Oregon Trans Health Coalition
If/When/How: Lawyering for Reproductive Justice
Kaiser Permanente
Latino Network
Multnomah County Health Department, Community Health Centers
National Health Law Program
Oregon Nurses Association
NWAA Fund
Oregon Health and Sciences University
Oregon ACLU
Oregon Coalition of Local Health Officials
Oregon Department of Education
Oregon Department of Justice
Oregon Medical Association
Oregon Nurses Association
Oregon Primary Care Association
Oregon Transgender Healthcare Coalition
Oregon ACOG
Planned Parenthood Advocates of Oregon
Planned Parenthood Columbia Willamette
Planned Parenthood of Southwestern Oregon
SEIU 49
The Lilith Clinic
The Urban League of Portland

[i] Rodriguez, M.I, Lin, S.C., Steenland, M., & Mcconnell, J.K. (2022) Association Between Oregon's 12-month Contraceptive Supply Policy and Quantity of Contraceptives Dispensed. *Jama Health Forum. 3(2)*. doi:10.1001/jamahealthforum.2021.5146

[ii] Information provided by the Oregon Health Authority based on Hospital Reporting Program information which provides for information about which hospitals may claim non-medical exemptions. HHI indexes and values provided by the Oregon Health Authority.

[iii] Solomon, T., Uttley, L., HasBrouck, P., Jung, Y. (2020). Bigger and Bigger: The Growth of Catholic Health Systems. *Community Catalyst.*

[iv] Guttmacher Institute. (2019). Induced Abortion in the United States. https://www.guttmacher.org/fact-sheet/induced-abortion-united-states

[v] Bearak, J.M., Burke, K.L., & Jones, R.K. (2017). Disparities and change over time in distance women would need to travel to have an abortion in the USA: A spatial analysis. *The Lancet Public Health*, 2(11). https://doi.org/10.1016/s2468-2667(17)30158-5.

[vi] Bui, Q., Miller, C.C., Sanger-Katz, M. (2021). Where Abortion Access Would Decline if Roe v. Wade Were Overturned. *The New York Times.* https://www.nytimes.com/interactive/2021/05/18/upshot/abortion-laws-roe-wade-states.html

[vii] Bearak, J.M., Burke, K.L., & Jones, R.K. (2017). Disparities and change over time in distance women would need to travel to have an abortion in the USA: A spatial analysis. *The Lancet Public Health*, 2(11). https://doi.org/10.1016/s2468-2667(17)30158-5.

[viii] The Alliance. (2022). "The CPC Industry as a Surveillance Tool of the Post-Roe State" Alliance_CPC_Report_Feb2022_UrgentBrief2-10-22.pdf (alliancestateadvocates.org)

[ix] Alliance_CPC_Report_ExecutiveSummary2-2-22.pdf (alliancestateadvocates.org)

[x] https://alliancestateadvocates.org/crisis-pregnancy-centers/

[xi] Sexual Violence Prevention Resource Map (arcgis.com)