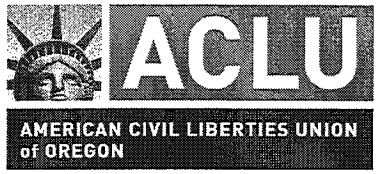

Testimony of Becky Straus, Legislative Director
In Opposition to SB 470A
House Committee on Health Care
May 8, 2013

Chair Greenlick and Members of the Committee:

Thank you for the opportunity to testify in regard to SB 470A, a proposal to expand the Oregon Prescription Drug Monitoring Program (PDMP). Because of the significant privacy concerns associated with collecting, storing, and sharing Oregonians' private medical information in a government-maintained database and because those concerns are only heightened by the changes in SB 470A, we are here today in strong opposition to the bill.

Federal Drug Enforcement Agency is Trying to Circumvent PDMP Privacy Protections

First and foremost, until we know whether the federal government will have unchecked access to Oregonians' information, this is the wrong time to undertake *any* expansion of the PDMP.

The PDMP is not and never should be a law enforcement tool. In setting up the PDMP in 2009, the Legislature made this commitment with a provision that makes it unlawful for any law enforcement agency to access private patient or prescriber data without a warrant based on probable cause.[1] Despite this safeguard, **our fears of warrantless release of private medical information have come true**, as the federal Drug Enforcement Agency (DEA) has made multiple requests for these records using only an administrative subpoena. These administrative subpoenas are issued without a showing of probable cause and without being presented to a court, but are judicially enforceable if the recipient declines to honor them.[2]

In at least one case of which we are aware, records were released to DEA. In other instances, the PDMP has declined to hand over the records, citing the state law warrant requirement. DEA and the State of Oregon are now in court battling over whether DEA can get the records. In briefs filed in that case, DEA has stated that it will issue approximately two subpoenas to the PDMP per month for the foreseeable future. The ACLU of Oregon has been granted our motion to intervene in the case, asserting that the DEA's use of administrative subpoenas to access patient and prescriber records is an unlawful invasion of privacy.

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[1] ORS 431.966(2)(a)(C)
[2] 21 U.S.C. 876

In Uncertain Times, SB 470A Significantly Expands PDMP to Collect and Share Too Much

Section 1

- *Allows for access by practitioners licensed in California, Idaho, and Washington.*

Testimony on the Senate side cited only the need for access by Washington doctors, so we recommend expanding only to these doctors. In addition, please consider adding further language to say that the doctor is "providing medical treatment to Oregon patients and is prescribing or considering prescribing any drug included in the PDMP."

Section 2

- *Gives Board of Pharmacy rulemaking authority to add any prescription drug to the PDMP.*

Of all the changes proposed in SB 470A, this proposal most threatens federal and state privacy laws by providing to the Board of Pharmacy the authority to add *any* prescription drug to the list of those monitored through the PDMP. Further, delegating such discussion to the rulemaking process would cede control of this carefully crafted list of drugs currently being monitored to the Board of Pharmacy. If the Legislature must add more drugs to be tracked, it should most certainly engage in deliberative debate over which specific drugs to add and why.

- *ACLU requested amendment:*

Current law requires that OHA submit an annual report to the PDMP Advisory Commission regarding the program. ACLU requests that you add language to Section 2(3) to say that "the report shall include all information related to possible and actual improper disclosure or use of the system, segregated by incident."

Section 3

- *Adds sex, prescription number, number of days for which drug was dispensed, number of refills of prescription authorized by practitioner and the number of the refill that the pharmacy dispensed.*

The addition of new data points to the list of information collected about patients and their prescriptions, especially "sex," are each seemingly unrelated to effective health care delivery. It is unclear why it is necessary to collect this new information.

Section 4

- *Allows practitioner or pharmacist to delegate receipt of information to staff.*

This change would open access to unlimited numbers of staff in a doctor or pharmacist office with no additional accountability mechanism for staff misuse of the database or the records. Very few states in the nation provide this kind of open access to the database by staff.[3] Other states do allow for delegation of access to the database, but with sidebars. Some states limit

[3] Kentucky, Maine, New York, West Virginia

delegation to one staff person. Others limit delegation only to those in the office who hold professional licensure.

Having monitored PDMP updates to the PDMP Advisory Commission over the interim, it is my understanding that this provision is meant to promote greater participation in the PDMP. In a survey conducted by the PDMP, many practitioners reported that a barrier to their participation is the inability to designate others in the office to access the PDMP when needed. For this reason, if the committee choses to adopt this provision, we strongly recommend that you provide the below language:

> A practitioner may designate one health care professional who is licensed, registered or certified by an Oregon health regulatory board to submit an application to seek access to the system in compliance with the Authority's rules. That authorized health care professional must be employed at the same facility, and at all times remain under the direct supervision of the delegating practitioner. To receive information under this subsection, the health care professional staff member must certify that the requested information is for the purpose of evaluating the need for or providing medical treatment for a patient to whom the delegating practitioner anticipates providing, is providing or has provided a prescription drug included in the prescription monitoring program. It is the responsibility of the delegating practitioner to insure that the authorized health care professional maintains the confidentiality of the information obtained from the Prescription Drug Monitoring Program. The delegating practitioner must notify the Authority if any of these requirements cease to exist or for any other reason it is no longer appropriate for the authorized health care professional to have access to the system. Upon receipt of notice, the Authority shall terminate access of the authorized health care professional.

- *Allows practitioner to receive disclosure "in a form that catalogs all prescription drugs prescribed by the practitioner according to the number assigned to the practitioner by the DEA."*

Providing the ability for practitioners to search by DEA number directly compromises the original intent of the program, which is meant to be a neither a tool for law enforcement nor a tool to "evaluate a practitioner's professional practice."[4]

- *Allows disclosure "to State Medical Examiner or designee of the State Medical Examiner, for the purpose of conducting medicolegal investigation or autopsy."*

It is unclear what is meant by "medicolegal investigation." Taken literally, "medicolegal" means medicine and the law. Again, the PDMP has never been and never should be a law enforcement tool but rather a mechanism to curb misuse of certain prescription drugs and allow for more opportunities for doctors and patients to discuss pain management strategies.

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[4] ORS 431.966(1)(b)

Disclosure to the State Medical Examiner is outside the original scope of the program and we request that you refrain from providing such access at this time. If the committee determines it is necessary to provide access to the State Medical Examiner, we respectfully urge you to include a probable cause warrant requirement, as is current law for any other law enforcement investigation.

- *Permits disclosure to: "a practitioner or pharmacist, as part of an automated system integrated into the prescription monitoring program by the authority that is designed to notify the practitioner or pharmacist of a potentially dangerous drug interaction, or of prescriptions made by multiple practitioners, for a patient of that practitioner or pharmacist."*

Essentially this provision would allow for PDMP to deploy an alert system to notify a patient's doctors or pharmacists of multiple prescriptions or an interaction of prescriptions trigged by a vague standard of "potentially dangerous."[5] Use of the PDMP in this way raises both practical and philosophical concerns. Practically, it is unclear exactly how such alert system would be developed and monitored for accuracy. Further, reliance on such an alert system could present frequent and significant problems for patients seeking the care they need. If an alert has been issued in error, a patient will face undue delay in obtaining his or her medication. If an alert was not issued but should have been, a doctor or pharmacist may rely on the absence of an alert and not sufficiently consider whether issuing the prescription is best for that patient. Philosophically, this change is a not-insignificant expansion of the program. PDMP is not set up to serve as a medical record and should not be relied on as such. Doing so would, from our perspective, be embarking on a new frontier for the program that carries more risks than it does benefits.

- *Allows disclosure of information that does not identify patient, practitioner, or drug outlet to local public health authority.*

Current law provides for disclosure of de-identified data "for public health purposes,"[6] so it is unclear why this provision is needed.

Section 6

- *Exempt from public records disclosure "information reported to OHA under ORS 431.964, information disclosed by the authority under ORS 431.966 and any information related to disclosures made by the authority under ORS 431.966, including information identifying the recipient of the information."*

Among the data exempt from public record under this section would be information about which practitioners have signed on to the PDMP. Again, in light of the great uncertainty surrounding the protection of prescriber information and private patient medical information, the public should have a right to know which practitioners are participating in the program.

If the committee choses to move forward with the inclusion of this exception, we ask that you place the exemption in ORS 192.502, where there is a public interest exemption for disclosure.

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[6] ORS 431.966(2)(b)(A)

Please refrain from making any changes to the PDMP at this time

The original intent of the PDMP was to study and address the misuse of prescription drugs in Oregon. The PDMP has never meant to be a law enforcement tool, nor has it been meant to replace a medical record, be a vehicle to collect large amounts of private data about innocent people, or share indiscriminately what is stored.

We know for sure now that the federal government is interested and is actively seeking this information for law enforcement purposes and without probable cause. Unless and until we can be sure that Oregonians' private medical information is secure, we should not do anything to expand the program. In fact, the best approach is to suspend the program altogether until the disposition of the court action.

Thank you for your consideration of our comments. We respectfully urge you to refrain from moving forward with SB 470A.