Seventy-Eighth Oregon Legislative Assembly - 2015 Regular Session **MEASURE: SB 523 A**
STAFF MEASURE SUMMARY **CARRIER: Sen. Steiner Hayward**
Senate Committee On Health Care

Fiscal: Has minimal fiscal impact
Revenue: No Revenue Impact

Action Date: 04/20/15
Action: Do Pass With Amendments. (Printed A-Eng.)
Meeting Dates: 04/06, 04/20
Vote:
Yeas: 5 - Knopp, Kruse, Monnes Anderson, Shields, Steiner Hayward
Prepared By: Zena Rockowitz, Committee Administrator

WHAT THE MEASURE DOES:
Requires insurer to notify provider that enrollee is in grace period when enrollee fails to pay premium for qualified health plan, if provider requests information regarding coverage, eligibility or benefits. Requires insurer to reimburse provider for services performed during grace period when coverage is terminated if insurer fails to notify provider and service is covered by plan. Specifies requirements may not be waived by agreement or contract. Directs insurer, upon inquiries from provider, to respond that coverage is provided. Directs Department of Consumer and Business Services to produce written materials for consumers about paying premiums and distribute to providers upon request.

ISSUES DISCUSSED:

- Federal rules on grace period did not set requirements for how to notify providers of patient's status
- Who bears the responsibility for non-payment of services rendered
- Communication between insurance companies, providers and patients regarding coverage
- Confusion among patients and providers regarding coverage
- Gaps in coverage and incentives to reinstate coverage

EFFECT OF COMMITTEE AMENDMENT:
Modifies requirements for notifying provider. Requires if enrollee fails to pay premium for qualified health plan, insurer must notify provider that enrollee is in grace period if provider requests information regarding coverage, eligibility or benefits. Adds that insurer that terminates coverage due to non-payment in grace period must pay claim if the service is covered in the enrollee's plan. Specifies requirements may not be waived by agreement and contract.

BACKGROUND:
The federal Affordable Care Act (ACA) and subsequent regulations released by the Centers for Medicare and Medicaid Services (CMS) have established requirements for qualified health insurance plans on the health insurance exchange. If enrollees do not pay their premiums in full, this starts a 90-day grace period in which an insurer cannot cancel the policy. During the first 30 days of the grace period, insurers must pay claims for services provided to enrollees during that time. If the enrollee does not pay the premium in full by the end of the grace period, the insurer can deny claims for services provided during the last 60 days of the grace period. Therefore, the patient is responsible for payment. Providers checking on a patient's eligibility with the health insurer and health insurers are required to notify providers of an enrollee's grace period status, but there is nothing to specify how much notice must be given or when the patient has entered the grace period.

This summary has not been adopted or officially endorsed by action of the Committee.