SB 1549 A STAFF MEASURE SUMMARY **Carrier:** Sen. Monnes Anderson

Senate Committee On Health Care

Action Date:	02/14/18
Action:	Do pass with amendments. (Printed A-Eng.)
Vote:	5-0-0-0
Yeas:	5 - Beyer, DeBoer, Knopp, Monnes Anderson, Steiner Hayward
Fiscal:	Fiscal impact issued
Revenue:	No revenue impact
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WHAT THE MEASURE DOES:

Specifies allowing the Oregon Health Authority (OHA) and Department of Human Services (DHS) to continue Medicaid for a person admitted to a state hospital, allows the Department of Consumer and Business Services (DCBS) to approve certain filings for health benefit plans qualifying for a health savings account (HSA), and requires health insurers to reimburse out-of-network providers for specified services in an amount established in rule by the DCBS.

Allows OHA and DHS to continue Medicaid coverage for a person admitted to a state hospital. Allows people whose medical assistance is terminated while admitted to a state hospital to apply for medical assistance 120 days prior to their expected release date.

Allows DCBS to approve a filing for a health benefit plan that qualifies for a health savings account distribution and is subject to certain Insurance Code provisions, under specified conditions. Applies to health benefit plans issued or renewed on or after January 1, 2019.

Requires health insurers to reimburse out-of-network providers for emergency services or other covered inpatient or outpatient services provided at an in-network health care facility in an amount established in rule by DCBS. Requires DCBS to adopt rules for calculating the reimbursement paid to providers with specified requirements. Requires DCBS to report to the legislature on consumer complaints concerning billing, adequacy of provider networks, effects on premiums, and recommendations for compliance by July 1, 2020. Becomes operative on January 1, 2019. Repeals certain provisions on January 2, 2021.

Declares emergency, effective upon passage.

ISSUES DISCUSSED:

- Difficulties transitioning individuals from Oregon State Hospital to community due to lack of benefits
- Alignment with Internal Revenue Service requirements for HSAs
- Overview of balance billing work group
- Difficulties determining balance billing reimbursement rate between medical providers and health insurance carriers

EFFECT OF AMENDMENT:

Allows DHS and OHA to continue Medicaid for a person admitted to the state hospital. Allows people whose medical assistance is terminated, while admitted to a state hospital, to apply for medical assistance 120 days prior to their expected release date.

Creates new provisions related to health benefit plan filings and HSAs.

Creates new provisions related to reimbursement of out-of-network providers for emergency services or other covered inpatient or outpatient services provided at an in-network health care facility.

BACKGROUND:

Institutions for mental diseases are prohibited under federal law from receiving Medicaid reimbursements for services provided to patients in these institutions. The term "institution for mental diseases" is defined in federal law as a hospital, nursing facility, or other institution of more than 16 beds, providing care to persons with mental diseases (42 U.S. Code § 1396d). The Oregon State Hospital is the only institution for mental disease in Oregon to which the law applies. Senate Bill 1549-A allows OHA or DHS to continue Medicaid coverage for a person admitted to the Oregon State Hospital and allows people whose medical assistance is terminated while admitted to the Oregon State Hospital to apply for medical assistance 120 days prior to their expected release date.

Health savings accounts (HSAs) are personal savings accounts funded with pre-tax dollars designed to help individuals with high-deductible health insurance plans pay for certain out-of-pocket medical costs. In Oregon, four commercial carriers reported having a total of over 112,000 HSA-eligible health insurance plans during 2016. Senate Bill 1549-A allows DCBS to approve filings for health benefit plan policies qualifying for a HSA distribution and subject to a specific prohibition in the Insurance Code.

Balance or surprise billing describes situations when a consumer is billed the difference between the medical provider's charge and the allowed health insurance amount of money to be paid for medical care. In 2017, the Oregon legislature passed House Bill 2339 which prohibits balance billing to occur for insured patients when receiving services from an out-of-network provider. Senate Bill 1549-A requires health insurers to reimburse out-of-network providers for emergency services or other covered inpatient or outpatient services provided at an in-network health care facility in an amount established in rule by the DCBS.