SB 1549 B STAFF MEASURE SUMMARY **Carrier:** Rep. Nosse

House Committee On Health Care

Action Date:	02/23/18
Action:	Do pass with amendments to the A-Eng bill. (Printed B-Eng.)
Vote:	11-0-0-0
Yeas:	11 - Alonso Leon, Boles, Buehler, Greenlick, Hayden, Kennemer, Keny-Guyer, Malstrom, Nosse, Salinas, Vial
Fiscal:	Fiscal impact issued
Revenue:	No revenue impact
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WHAT THE MEASURE DOES:

Allows OHA and DHS to continue Medicaid coverage for a person admitted to a state hospital. Allows individuals with Medicaid coverage that is terminated while admitted to a state hospital to apply for Medicaid 120 days prior to their expected release date. Authorizes 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 legislative committees on health care 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:

- Results of the balance billing work group led by DCBS as directed by HB 2339 (2017)
- Proposed reimbursement methodology and rates for providers affected by the bill
- Potential amendment to address a scope of practice conflict among the Oregon State Board of Nursing and the Oregon Board of Medical Imaging
- Whether individual units of the Oregon State Hospital can qualify under the “16 bed” provision to be defined as an “institution for mental diseases” (IMD) as opposed to the entire hospital
- Consistency of the qualification to be defined as an IMD over variants in size of service area population

EFFECT OF AMENDMENT:

Removes requirement that DCBS consult with health professional licensing boards on consumer complaints.

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-B

allows DCBS to approve filings for health benefit plan policies qualifying for an 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. The bill also directed DCBS to convene an advisory group that included health care providers, insurers, and consumer advocates to develop recommendations for the reimbursement of services provided to enrollees by out-of-network providers at in-network health care facilities. In 2017, the advisory group convened five times between August and November and ultimately considered four options on the reimbursement methodology. The advisory group ultimately did not reach a consensus recommendation but did agree upon using Oregon's All-Payer All-Claims (APAC) as the data source to craft reimbursement rates, which should also vary by geographic region. Senate Bill 1549-B 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.

Senate Bill 1549-B does the following; (1) allows OHA or DHS to continue Medicaid coverage for a person admitted to the Oregon State Hospital, (2) grants DCBS authority to approve filings for health benefit plan policies qualifying for a HSA distribution and subject to a specific prohibition in the Insurance Code, and (3) requires health insurers to reimburse out-of-network providers for covered services provided at an in-network health care facility in an amount to be established in rule by the DCBS.