FISCAL IMPACT OF PROPOSED LEGISLATION **Measure: HB 3108 - 6**

81st Oregon Legislative Assembly – 2021 Regular Session
Legislative Fiscal Office

Only Impacts on Original or Engrossed Versions are Considered Official

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Measure Description:
Requires individual and group health insurance policies, health care service contractors, multiple employer welfare arrangements and state medical assistance program to provide reimbursement for at least three primary care visits annually.

Government Unit(s) Affected:
Oregon Health Authority (OHA), Department of Consumer and Business Services (DCBS)

Summary of Fiscal Impact:
Costs related to the measure may require budgetary action - See analysis.

Summary of Expenditure Impact:

	2021-23 Biennium	2023-25 Biennium
General Fund	165,820	
Federal Funds	497,462	
Total Funds	**$663,282**	**$0**
Positions	0	0
FTE	0.00	0.00

Analysis:
HB 3108 - 6 requires that an individual or group policy or certificate of health insurance that is not offered on the health insurance exchange, and that reimburses the cost of hospital, medical or surgical expenses, must reimburse the cost of at least three visits to a primary care provider (PCP) each year. This coverage may not be subject to copayments, coinsurance, or deductibles, and is in addition to the yearly preventive primary care visit that must be covered without cost sharing. Insurers that offer health plans on the health insurance exchange must offer at least one plan in each metal tier offered by the insurer that provides this coverage.

This measure also prohibits an individual or group policy or certificate of health insurance from excluding coverage for a behavioral or physical health service on the basis that these services were provided on the same day or in the same facility; from imposing a copayment for physical or behavioral health services provided by an in-network provider if on the same day a copayment was imposed for other services; or from requiring prior authorization for a covered behavioral health service provided by a specialist in a behavioral health home or patient centered primary care home. The Department of Consumer and Business Services (DCBS) is to adopt rules for assignment of PCPs by insurers.

The Oregon Health Authority (OHA) and coordinated care organizations (CCOs) may not deny a claim for reimbursement for a behavioral or physical health service provided to a medical assistance recipient on the basis that these services were provided on the same day or in the same facility, though this does not apply to CCO payments to providers using a value-based payment arrangement or other alternative payment methodology. CCOs may not require prior authorization for specialty behavioral health services provided to a medical assistance

recipient unless permitted by OHA. OHA is to adopt rules consistent with the rules adopted by DCBS for assigning PCPs, and OHA and CCOs are to assign PCPs to people with medical assistance coverage.

These changes to coverage apply to policies or certificates of insurance issued, renewed or extended on or after October 1, 2022, for coverage during the 2023 plan year.

This measure warrants a subsequent referral to the Joint Committee on Ways and Means for consideration of its budgetary impact.

Oregon Health Authority
There is an indeterminate impact related to the requirement that OHA assign a PCP if a medical assistance recipient who is not enrolled in a CCO has not selected one.

OHA anticipates costs of $663,282 total funds ($165,820 General Fund) due to modifications to the Medicaid Management Information System (MMIS) needed in order to track the member's PCP assignment.

OHA also contracts with an outside entity that maintains a fee-for-service (FFS) care coordination dashboard and identifies providers serving FFS clients. It is not clear if this contractor already tracks members without PCPs or if PCP assignments would ultimately be tracked using only MMIS, or also contracted services. OHA notes a possible indeterminate increase to the contractor agreement, which could increase the contract's not-to-exceed agreement by approximately $192,000 to $383,000 total funds, with an estimated General Fund contribution of $48,000 to $96,000.

Department of Consumer and Business Services
DCBS anticipates minimal fiscal impact from this measure. However, the agency notes that the expansion of coverage requirements for health benefit plans may be considered a new mandate under the Patient Protection and Affordable Care Act. This requires states to offset the cost of mandated benefits enacted after December 2011 for plans issued through the health insurance marketplace. The federal guidance does not clarify whether offsets must be paid out of the General Fund or from other state funds such as marketplace assessment funds, but the bill may have an overall fiscal impact to the state.