PRELIMINARY

HB 2690 STAFF MEASURE SUMMARY

House Committee On Behavioral Health and Health Care

Prepared By:	Brian Nieubuurt, LPRO Analyst
Sub-Referral To:	Joint Committee On Ways and Means
Meeting Dates:	2/13

WHAT THE MEASURE DOES:

The measure establishes the Health Insurance Mandate Review Advisory Committee (HIMRAC) to review proposed measures that require a health insurance plan to provide coverage for a specific service or reimburse specific providers and produce a report containing specified information about the proposed coverage requirement.

Detailed Summary

- Establishes HIMRAC and specifies membership to be jointly appointed by the President of the Senate and the Speaker of the House.
- Specifies process for chairperson or vice chairperson of an interim committee to submit analysis requests to HIMRAC; limits requests to four during an interim following an even-numbered year session and two following an odd-numbered year session.
- Specifies timelines for Legislative and Policy Research Office (LPRO) Director to collect and compile data needed by HIMRAC to conduct analysis.
- Specifies information to be included in HIMRAC analysis, including an assessment of the financial effects based on an actuarial analysis conducted by the Department of Consumer and Business Services (DCBS); prohibits report from containing a policy recommendation.
- Requires LPRO Director, in collaboration with DCBS Director and HIMRAC to report to Legislative Assembly on implementation of HIMRAC by September 15, 2027.
- Sunsets HIMRAC June 30, 2028.
- Beginning June 30, 2028 requires every proposed legislative measure that mandates a health insurance coverage to be accompanied by a report assessing the social and financial effects of the coverage; specifies questions to be answered by the report.

FISCAL: *May have fiscal impact, but no statement yet issued.*

REVENUE: *May have revenue impact, but no statement yet issued.*

ISSUES DISCUSSED:

EFFECT OF AMENDMENT:

No amendment.

BACKGROUND:

As with other forms of insurance, people obtain health insurance to protect themselves against significant future potential costs. Health insurance can be provided by governments (e.g., Medicare and Medicaid) or the private sector (e.g., employer-sponsored and individual market coverage). While the 1945 McCarran-Ferguson Act established states as the primary regulators of the business of insurance, overlapping federal laws like the Employee Retirement Income Security Act of 1974 (ERISA; P.L. 93-406), the Health Insurance Portability and Accountability Act of 1996 (HIPAA; P.L. 104-191), and the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) complicate the regulation of health insurance. For example, ERISA outlines federal

minimum standards for employer-sponsored health insurance that is self-funded and preempts state regulation of those plans, thereby largely limiting state regulation of private sector health insurance to the small group and individual markets.

State regulation of health insurance can take many forms, including mandates related to persons covered (e.g., coverage of dependents or certain conditions), provider types, and services. With insurance working by spreading risk across a coverage group, the introduction of new state mandates on health insurance has implications for the cost of that coverage. Since 1985, Oregon law has required that every proposed piece of legislation mandating health insurance coverage be accompanied by a report assessing both the social and financial effects of the coverage, including the efficacy of the treatment or service proposed (ORS 171.870 - 171.880).

House Bill 2690 establishes the Health Insurance Mandate Review Advisory Committee (HIMRAC) to review proposed measures that require a health insurance plan to provide coverage for a specific service or reimburse specific providers and produce a report containing specified information about the proposed coverage requirement.

PRELIMINARY