Seventy-Eighth Oregon Legislative Assembly - 2015 Regular Session **MEASURE: SB 523 B**

STAFF MEASURE SUMMARY **CARRIER: Rep. Kennemer**

House Committee On Health Care

Fiscal: Has minimal fiscal impact
Revenue: No Revenue Impact

Action Date: 06/01/15
Action: Do Pass As Amended And Be Printed Engrossed.
Meeting Dates: 05/13, 06/01
Vote:
Yeas: 9 - Buehler, Clem, Greenlick, Hayden, Kennemer, Keny-Guyer, Lively, Nosse, Weidner
Prepared By: Sandy Thiele-Cirka, Committee Administrator

WHAT THE MEASURE DOES:
Requires insurer to notify provider that the enrollee is in a grace period when enrollee fails to pay premium for the qualified health plan, if the provider requests information regarding coverage, eligibility or benefits. Specifies conditions that requires insurer to reimburse provider for services performed during the grace period when coverage is terminated. Specifies requirements may not be waived by agreement or contract. Directs insurer, upon inquiries from provider, to respond that coverage is provided. Requires that a provider request the information from the insurer not more than seven (7) business days before providing the service and that the insurer provides the information to the provider no later than two (2) business days after the request is made. Directs Department of Consumer and Business Services to produce written materials for consumers about paying premiums and distribute to providers upon request.

ISSUES DISCUSSED:

- Current administrative burden
- Need for current information for providers
- Grace period negative consequences
- Impact to providers
- Insurers concerns
- Proposed amendment

EFFECT OF COMMITTEE AMENDMENT:
Adds the requirement that a provider request the information from the insurer not more than 7 business days before providing the service and that the insurer provides the information to the provider no later than 2 business days after the request is made.

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 that are offered on a 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 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.