A-Engrossed

Senate Bill 1549

Ordered by the Senate February 16
Including Senate Amendments dated February 16

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SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure.

[*Requires*] **Allows** continuation of medical assistance for specified period following admission to state hospital.

Permits Department of Consumer and Business Services to approve health benefit plan that fails to comply with state prohibition on application of deductible if necessary to qualify plan for health savings account.

Requires insurer and health care service contractor to reimburse out-of-network providers for services provided at in-network facilities in amount established by department in accordance with specified standards. Sunsets provisions on January 2, 2022.

Requires department to report to interim committees of Legislative Assembly related to health, by July 1, 2020, on effects of changes in law on complaints of surprise billing, network adequacy, premium rates and enforcing compliance with new requirements.

Declares emergency, effective on passage.

1 **A BILL FOR AN ACT**

2 Relating to health care; creating new provisions; amending ORS 411.439 and 743B.287; and declaring
3 an emergency.

4 **Be It Enacted by the People of the State of Oregon:**

5 **SECTION 1.** ORS 411.439 is amended to read:

6 411.439. (1) As used in this section:

7 (a) "Person with a serious mental illness" means a person who is diagnosed by a psychiatrist,
8 a licensed clinical psychologist or a certified nonmedical examiner as having dementia,
9 schizophrenia, bipolar disorder, major depression or other affective disorder or psychotic mental
10 disorder other than a disorder caused primarily by substance abuse.

11 **(b) "Recertification date" means the date 12 months after the date an application for**
12 **medical assistance was last approved or renewed.**

13 [*(b)*] **(c)** "State hospital" has the meaning given that term in ORS 162.135.

14 [*(2) Except as provided in subsections (6) and (7) of this section, the Department of Human Services*
15 *or the Oregon Health Authority shall suspend, instead of terminate, the medical assistance of a person*
16 *with a serious mental illness when:*]

17 [*(a) The person receives medical assistance because of a serious mental illness; and*]

18 [*(b) The person is admitted to a state hospital.*]

19 [*(3) The department or the authority shall continue to determine the eligibility of the person for*
20 *medical assistance.*]

21 [*(4) Upon notification that a person described in subsection (2) of this section is no longer residing*

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

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in a state hospital or that the person is admitted to a medical institution outside of the state hospital for a period of hospitalization, the department or the authority shall reinstate the person's medical assistance if the person is otherwise eligible for medical assistance.]

(2) The Department of Human Services and the Oregon Health Authority may continue the medical assistance of a person who is admitted to a state hospital until the earlier of:

(a) Twelve months after the person is admitted to the state hospital; or

(b) The person's recertification date.

[*(5)*] **(3)** This section does not extend eligibility to an otherwise ineligible person or extend medical assistance to a person if matching federal funds are not available to pay for medical assistance.

[*(6)*] **(4)** Subsection (2) of this section does not apply to a person with a serious mental illness residing in a state hospital who is under 22 years of age or who is 65 years of age or older.

[*(7)*] **(5)** A person with a serious mental illness **whose medical assistance is terminated while the person is admitted to a state hospital** may apply for medical assistance [*between 90 and*] **up to** 120 days prior to the expected date of the person's release from a state hospital. If the person is found to be eligible, the effective date of the person's medical assistance shall be the date of the person's release from the state hospital.

SECTION 2. Section 3 of this 2018 Act is added to and made a part of the Insurance Code.

SECTION 3. (1) As used in this section:

(a) "Health benefit plan" has the meaning given that term in ORS 743B.005.

(b) "Health savings account" means an account established under section 223 of the Internal Revenue Code.

(2) This section applies to a health benefit plan that is:

(a) Offered by a carrier as a plan that qualifies for a health savings account distribution; and

(b) Subject to a provision of the Insurance Code that prohibits a health benefit plan from applying a deductible to a specified health care service that is reimbursed by the health benefit plan.

(3) The Department of Consumer and Business Services may approve a filing under ORS 742.003 for a health benefit plan described in subsection (2) of this section if:

(a) The health benefit plan would be approved but for the failure of the plan to comply with the provision described in subsection (2)(b) of this section;

(b) A deductible must be applied to the specified health care service for the plan to qualify for a distribution from a health savings account; and

(c) The health benefit plan complies with all other applicable provisions of the Insurance Code.

SECTION 4. ORS 743B.287 is amended to read:

743B.287. (1) As used in this section:

(a) "Allowed amount" means the reimbursement paid by an insurer or health care service contractor to a health care provider for a specified service or group of services covered by a health benefit plan or a health care service contract.

[*(a)*] **(b)** "Emergency services" has the meaning given that term in ORS 743A.012.

[*(b)*] **(c)** "Enrollee" means:

(A) An individual who is enrolled in a health benefit plan or a covered dependent or beneficiary of the individual; or

(B) A subscriber to a health care service contract or a covered dependent or beneficiary of the subscriber.

[*(c)*] **(d)** "Health benefit plan" has the meaning given that term in ORS 743B.005.

[*(d)*] **(e)** "Health care facility" has the meaning given that term in ORS 442.015, excluding long term care facilities.

[*(e)*] **(f)** "Health care service contractor" has the meaning given that term in ORS 750.005.

[*(f)*] **(g)** "In-network" has the meaning given that term in ORS 743B.280.

[*(g)*] **(h)** "Out-of-network" has the meaning given that term in ORS 743B.280.

(2) [*Except as provided in subsection (3) of this section,*] A provider who is an out-of-network provider for a health benefit plan or health care service contract may not bill an enrollee in the health benefit plan or health care service contract for emergency services or other inpatient or outpatient services provided at an in-network health care facility.

(3) An insurer offering a health benefit plan and a health care service contractor shall reimburse an out-of-network provider for emergency services or other covered inpatient or outpatient services provided at an in-network health care facility in an amount established in accordance with rules adopted by the Department of Consumer and Business Services under subsection (6) of this section.

[*(3)*] **(4)** [*Subsection (2)*] **Subsections (2) and (3)** of this section [*does*] **do** not apply:

(a) To applicable coinsurance, copayments or deductible amounts that apply to services provided by an in-network provider; or

(b) To services, other than emergency services, provided to enrollees who choose to receive services from an out-of-network provider.

[*(4)*] **(5)** If an enrollee chooses to receive services from an out-of-network provider, the provider shall inform the enrollee that the enrollee will be financially responsible for coinsurance, copayments or other out-of-pocket expenses attributable to choosing an out-of-network provider.

(6) The department shall adopt rules for calculating the reimbursement that must be paid to providers under subsection (3) of this section. The reimbursement must be equal to the median allowed amount paid to in-network health care providers by commercial insurers in this state, based on data collected under ORS 442.466 for the 2015 calendar year, adjusted annually using the U.S. City Average Consumer Price Index for All Urban Consumers (All Items) as published by the Bureau of Labor Statistics of the United States Department of Labor. The Department of Consumer and Business Services may adjust the amount of reimbursement based on the differences in allowed amounts paid to health care providers in certain geographic areas of this state.

SECTION 5. (1) No later than July 1, 2020, the Department of Consumer and Business Services shall report to the interim committees of the Legislative Assembly related to health, in the manner provided in ORS 192.245, all of the following:

(a) All consumer complaints presented to the department concerning billing for services provided in in-network facilities by out-of-network providers, as defined in ORS 743B.287, before and after March 1, 2018;

(b) Any effects on the adequacy of provider networks after January 1, 2019, due to the implementation of the amendments to ORS 743B.287 by section 4 of this 2018 Act, measured by the standards prescribed under ORS 743B.505;

(c) Any effects on premium rates after March 1, 2018, due to the implementation of ORS 743B.287; and

1 **(d) Recommendations for methods to ensure compliance with the provisions of ORS**
2 **743B.287.**
3 **(2) The department shall consult with health professional licensing boards in preparing**
4 **the information described in subsection (1)(a) of this section.**
5 **SECTION 6.** ORS 743B.287, as amended by section 4 of this 2018 Act, is amended to read:
6 743B.287. (1) As used in this section:
7 [*(a) "Allowed amount" means the reimbursement paid by an insurer or health care service con-*
8 *tractor to a health care provider for a specified service or group of services covered by a health benefit*
9 *plan or a health care service contract.*]
10 [*(b)*] **(a)** "Emergency services" has the meaning given that term in ORS 743A.012.
11 [*(c)*] **(b)** "Enrollee" means:
12 (A) An individual who is enrolled in a health benefit plan or a covered dependent or beneficiary
13 of the individual; or
14 (B) A subscriber to a health care service contract or a covered dependent or beneficiary of the
15 subscriber.
16 [*(d)*] **(c)** "Health benefit plan" has the meaning given that term in ORS 743B.005.
17 [*(e)*] **(d)** "Health care facility" has the meaning given that term in ORS 442.015, excluding long
18 term care facilities.
19 [*(f)*] **(e)** "Health care service contractor" has the meaning given that term in ORS 750.005.
20 [*(g)*] **(f)** "In-network" has the meaning given that term in ORS 743B.280.
21 [*(h)*] **(g)** "Out-of-network" [*has the meaning given that term in ORS 743B.280*] **means a provider**
22 **or provider group that has not contracted or has indirectly contracted with the insurer or**
23 **health care service contractor**.
24 (2) A provider who is an out-of-network provider [*for a health benefit plan or health care service*
25 *contract*] may not bill an enrollee in the health benefit plan or health care service contract for
26 emergency services or other inpatient or outpatient services provided at an in-network health care
27 facility.
28 [*(3) An insurer offering a health benefit plan and a health care service contractor shall reimburse*
29 *an out-of-network provider for emergency services or other covered inpatient or outpatient services*
30 *provided at an in-network health care facility in an amount established in accordance with rules*
31 *adopted by the Department of Consumer and Business Services under subsection (6) of this section.*]
32 [*(4)*] **(3)** [*Subsections (2) and (3)*] **Subsection (2)** of this section [*do*] **does** not apply:
33 (a) To applicable coinsurance, copayments or deductible amounts that apply to services provided
34 by an in-network provider; or
35 (b) To services, other than emergency services, provided to enrollees who choose to receive
36 services from an out-of-network provider.
37 [*(5)*] **(4)** If an enrollee chooses to receive services from an out-of-network provider, the provider
38 shall inform the enrollee that the enrollee will be financially responsible for coinsurance,
39 copayments or other out-of-pocket expenses attributable to choosing an out-of-network provider.
40 [*(6) The department shall adopt rules for calculating the reimbursement that must be paid to pro-*
41 *viders under subsection (3) of this section. The reimbursement must be equal to the median allowed*
42 *amount paid to in-network health care providers by commercial insurers in this state, based on data*
43 *collected under ORS 442.466 for the 2015 calendar year, adjusted annually using the U.S. City Average*
44 *Consumer Price Index for All Urban Consumers (All Items) as published by the Bureau of Labor*
45 *Statistics of the United States Department of Labor. The Department of Consumer and Business Ser-*

vices may adjust the amount of reimbursement based on the differences in allowed amounts paid to health care providers in certain geographic areas of this state.]

SECTION 7. (1) The amendments to ORS 743B.287 by section 4 of this 2018 Act become operative on January 1, 2019.

(2) The amendments to ORS 743B.287 by section 6 of this 2018 Act become operative on January 2, 2022.

SECTION 8. Section 5 of this 2018 Act is repealed on January 2, 2021.

SECTION 9. Section 3 of this 2018 Act applies to health benefit plans issued or renewed on or after January 1, 2019.

SECTION 10. This 2018 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2018 Act takes effect on its passage.