OEBB/PEBB Rules Related to Hospital Payments

Overview

Senate Bill 1067 (2017) established a cap on OEBB and PEBB health benefit plan claims payments for inpatient and outpatient hospital services, with payment for in-network hospital services limited to 200% of the amount Medicare would pay for the services and payments to out-of-network hospitals limited to 185% of the amount Medicare would pay for the services.

The legislation included provisions specifying certain hospitals are not subject to these payment caps as well as language requiring that a health plan carrier or third-party administrator that does not reimburse claims on a fee-for-service basis take into account the limits established in SB 1067 when determining payments for hospital services. SB 1067 states that such non-fee-for-services payment methods include but are not limited to value-based payments, capitation payments, and bundled payments.

Draft Rules

Attachment 3a provides initial draft rules to clarify aspects of the hospital payment cap implementation for PEBB benefit plans. An exact copy of the final draft rules will be issued for OEBB so that consistent rules govern hospital payments in both programs. Clarifications in the draft rules include:

- General description of how PEBB will analyze payments to appropriately steward health benefit dollars consistent with the law
- PEBB requirements to ensure alternative (non-FFS) payment arrangements sufficiently take hospital payment limits into account
- Data source to determine percentage of total revenue derived from Medicare for the purpose of identifying certain exempt hospitals

Attachment 3b provides a listing of Oregon hospitals that are subject to the payment limits established in SB 1067, as well as those hospitals that are not subject to the cap. Further description of how exempt hospitals were identified using state data sources is provided in 101-080-0020 of the draft rules in Attachment 3a.

Next Steps

Once the Innovation Workgroup completes review of these initial draft rules the draft will move forward to both the OEBB and PEBB Boards for approval to file Notice and proceed through the permanent rulemaking process. Upon approval from the Boards, required Notice will be filed with the Secretary of State and draft rules will be released for comment. Staff currently anticipate that a rules hearing will be scheduled for mid-summer. All comment received will be reviewed and considered before final rules are sent to both Boards, with staff requesting approval to file rules permanently.

ORS 243.256 and 243.879 provide the statutory language regarding hospital payment limits for PEBB and OEBB, respectively, and are included below for reference.

243.256 Reimbursement methodology for payment to hospitals. (1) A hospital that provides services or supplies under a benefit plan offered by the Public Employees' Benefit Board shall be reimbursed using the methodology prescribed by the Oregon Health Authority under ORS 442.392 and may not be reimbursed for each service or supply provided.

(2) This section applies to hospital payments made by a carrier under a contract with the board and to hospital payments made under a self-insurance program administered by a third party administrator on behalf of the board.

(3) This section does not apply to reimbursements paid by a carrier or third party administrator to a hospital that is not subject to the methodology prescribed by the authority under ORS 442.392. [2011 c.418 §6]

Note: The amendments to 243.256 by section 29, chapter 746, Oregon Laws 2017, apply to health benefit plans offered by the Public Employees' Benefit Board for plan years beginning after July 1, 2019. See section 34, chapter 746, Oregon Laws 2017. The text that applies to plan years beginning after July 1, 2019, is set forth for the user's convenience.

243.256. (1) A carrier that contracts with the Public Employees' Benefit Board to provide to eligible employees and their dependents a benefit plan that reimburses the cost of inpatient or outpatient hospital services or supplies shall reimburse a claim for the cost of a hospital service or supply that is covered by, or is similar to a service or supply that is covered by, the Medicare program in an amount that does not exceed:

(a) For claims submitted by in-network hospitals, 200 percent of the amount paid by Medicare for the service or supply; or

(b) For claims submitted by out-of-network hospitals, 185 percent of the amount paid by Medicare for the service or supply.

(2) A self-insurance program administered by a third party administrator that is offered by the board to eligible employees and their dependents and that reimburses the cost of inpatient or outpatient hospital services or supplies shall reimburse a claim for the cost of a hospital service or supply that is covered by, or is similar to a service or supply that is covered by, the Medicare program in an amount that does not exceed:

(a) For claims submitted by in-network hospitals, 200 percent of the amount paid by Medicare for the service or supply; or

(b) For claims submitted by out-of-network hospitals, 185 percent of the amount paid by Medicare for the service or supply.

(3) A provider who is reimbursed in accordance with subsection (1) or (2) of this section may not charge to or collect from the patient or a person who is financially responsible for the patient an amount in addition to the reimbursement paid under subsection (1) or (2) of this section other than cost sharing amounts authorized by the terms of the health benefit plan.

(4) If a carrier or third party administrator does not reimburse claims on a fee-for-service basis, the payment method used must take into account the limits specified in subsections (1) and (2) of this section. Such payment methods include, but are not limited to:

(a) Value-based payments;

(b) Capitation payments; and

(c) Bundled payments.

(5) This section does not apply to reimbursements paid by a carrier or third party administrator to:

(a) A type A or type B hospital as described in ORS 442.470;

(b) A rural critical access hospital as defined in ORS 315.613; or

(c) A hospital:

(A) Located in a county with a population of less than 70,000 on August 15, 2017;

(B) Classified as a sole community hospital by the Centers for Medicare and Medicaid Services; and

(C) With Medicare payments composing at least 40 percent of the hospital's total annual patient revenue.

(6) This section does not require a health benefit plan offered by the board to reimburse claims using a fee-for-service payment method.

243.879 Reimbursement methodology for payment to hospitals. (1) A hospital that provides services or supplies under a benefit plan offered by the Oregon Educators Benefit Board shall be reimbursed using the methodology prescribed by the Oregon Health Authority under ORS 442.392 and may not be reimbursed for each service or supply provided.

(2) This section applies to hospital payments made by a carrier under a contract with the board and to hospital payments made under a self-insurance program administered by a third party administrator on behalf of the board.

(3) This section does not apply to reimbursements paid by a carrier or third party administrator to a hospital that is not subject to the methodology prescribed by the authority under ORS 442.392. [2011 c.418 §8]

Note: The amendments to 243.879 by section 31, chapter 746, Oregon Laws 2017, apply to health benefit plans offered by the Oregon Educators Benefit Board for plan years beginning after July 1, 2019. See section 34, chapter 746, Oregon Laws 2017. The text that applies to plan years beginning after July 1, 2019, is set forth for the user's convenience.

243.879. (1) A carrier that contracts with the Oregon Educators Benefit Board to provide to eligible employees and their dependents a benefit plan that reimburses the cost of inpatient or outpatient hospital services or supplies shall reimburse a claim for the cost of a hospital service or supply that is covered by, or is similar to a service or supply that is covered by, the Medicare program in an amount that does not exceed:

(a) For claims submitted by in-network hospitals, 200 percent of the amount paid by Medicare for the service or supply; or

(b) For claims submitted by out-of-network hospitals, 185 percent of the amount paid by Medicare for the service or supply.

(2) A self-insurance program administered by a third party administrator that is offered by the board to eligible employees and their dependents and that reimburses the cost of inpatient or outpatient hospital services or supplies shall reimburse a claim for the cost of a hospital service or supply that is covered by, or is similar to a service or supply that is covered by, the Medicare program in an amount that does not exceed:

(a) For claims submitted by in-network hospitals, 200 percent of the amount paid by Medicare for the service or supply; or

(b) For claims submitted by out-of-network hospitals, 185 percent of the amount paid by Medicare for the service or supply.

(3) A provider who is reimbursed in accordance with subsection (1) or (2) of this section may not charge to or collect from the patient or a person who is financially responsible for the patient an amount in addition to the reimbursement paid under subsection (1) or (2) of this section other than cost sharing amounts authorized by the terms of the health benefit plan.

(4) If a carrier or third party administrator does not reimburse claims on a fee-for-service basis, the payment method used must take into account the limits specified in subsections (1) and (2) of this section. Such payment methods include, but are not limited to:

(a) Value-based payments;

(b) Capitation payments; and

(c) Bundled payments.

(5) This section does not apply to reimbursements paid by a carrier or third party administrator to:

(a) A type A or type B hospital as described in ORS 442.470;

(b) A rural critical access hospital as defined in ORS 315.613; or

(c) A hospital:

(A) Located in a county with a population of less than 70,000 on August 15, 2017;

(B) Classified as a sole community hospital by the Centers for Medicare and Medicaid Services; and

(C) With Medicare payments composing at least 40 percent of the hospital's total annual patient revenue.

(6) This section does not require a health benefit plan offered by the board to reimburse claims using a fee-for-service payment method.