Enrolled
House Bill 2213

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CHAPTER .....

AN ACT

Relating to payments for procedures covered by health benefit plan.

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

SECTION 1. As used in sections 1 to 6 of this 2007 Act:

(1) "In-network" means performed by a provider or provider group that has directly contracted with the insurer.

(2) "Out-of-network" means performed by a provider or provider group that has not contracted or has indirectly contracted with the insurer.

SECTION 2. (1) An insurer offering a health benefit plan as defined in ORS 743.730 must establish a procedure for providing to an enrollee in the plan a reasonable estimate of an enrollee's costs for an in-network procedure or service covered by the enrollee's health benefit plan, in advance of the procedure or service, when an enrollee or an enrollee's authorized representative provides the following information to the insurer:

(a) The type of procedure or service;

(b) The name of the provider;

(c) The enrollee's member number or policy number; and

(d) If requested by the insurer, the site where the procedure or service will be performed.

(2) The estimate of costs described in subsection (1) of this section must include an itemization of:

(a) The enrollee's deductible;

(b) The amount of the deductible that has been met by processed claims;

(c) Coinsurance, copayment or other cost share to be paid by the enrollee for the procedure or service; and

(d) Any applicable benefit maximum.

(3) Subsections (1) and (2) of this section apply to the insurer's five most common procedures or services within each of the following categories:

(a) Office visits;

(b) Diagnostic radiology and imaging;

(c) Diagnostic pathology and laboratory procedures;

(d) Normal vaginal delivery;

(e) Immunizations;

(f) Orthopedic-musculoskeletal surgery; and

(g) Digestive system endoscopy.

(4) In addition to the information specified in subsections (1) and (2) of this section, the insurer's estimate must include the following disclosures:

(a) That other services may be provided to the enrollee that are medically necessary and appropriate as part of the common procedures, of which the insurer or enrollee may not be aware at the time of the inquiry and for which the enrollee may have additional financial responsibility;

(b) That the enrollee may be responsible for costs of procedures or services not covered by the plan;

(c) How an enrollee may contact the insurer for an explanation, if the estimate differs from the actual cost or if the enrollee has other questions; and

(d) The toll-free telephone number of the consumer advocacy unit of the Department of Consumer and Business Services and the address for the department's consumer information and complaints website.

(5) An insurer must make the information required by this section available to enrollees and in-network providers through an interactive website and by toll-free telephone.

(6) This section does not prohibit an insurer from providing information in addition to or in more detail than the information required by this section.

SECTION 3. (1) An insurer offering a health benefit plan as defined in ORS 743.730 must establish a procedure for providing to an enrollee in the plan a reasonable estimate of the enrollee's costs for an out-of-network procedure or service covered by the enrollee's health benefit plan, including the difference between the insurer's allowable charge and the billed charge for the procedure or service, in advance of the procedure or service, when an enrollee or an enrollee's authorized representative provides the following information to the insurer:

(a) The type of procedure or service;

(b) The name of the provider;

(c) The enrollee's member number or policy number;

(d) If requested by the insurer, the site where the procedure or service will be performed; and

(e) The provider's billed charge amount.

(2) The estimate of costs described in subsection (1) of this section must include an itemization of:

(a) The enrollee's deductible;

(b) The amount of the deductible that has been met by processed claims;

(c) Coinsurance, copayment or other cost share to be paid by the enrollee for the procedure or service;

(d) Any applicable benefit maximum;

(e) The difference between the insurer's allowable charge and the billed charge for the procedure or service; and

(f) The insurer's average payment or allowable charge for the procedure or service if performed in-network.

(3) Subsections (1) and (2) of this section apply to the insurer's five most common procedures or services within each of the following categories:

(a) Office visits;

(b) Diagnostic radiology and imaging;

(c) Diagnostic pathology and laboratory procedures;

(d) Normal vaginal delivery;

(e) Immunizations;

(f) Orthopedic-musculoskeletal surgery; and

(g) Digestive system endoscopy.

(4) In addition to the information specified in subsections (1) and (2) of this section, the insurer's estimate must include the following disclosures:

(a) That other services may be provided to the enrollee that are medically necessary and appropriate as part of the common procedures, of which the insurer or enrollee may not be aware at the time of the inquiry and for which the enrollee may have additional financial responsibility;

(b) That the enrollee may be responsible for costs of procedures or services not covered by the plan;

(c) How an enrollee may contact the insurer for an explanation, if the estimate differs from the actual cost or if the enrollee has other questions; and

(d) The toll-free telephone number of the consumer advocacy unit of the Department of Consumer and Business Services and the address for the department's consumer information and complaints website.

(5) An insurer must make the information required by this section available to enrollees and out-of-network providers through an interactive website and by toll-free telephone.

(6) This section does not prohibit an insurer from providing information in addition to or in more detail than the information required by this section.

SECTION 4. (1) An insurer offering a health benefit plan as defined in ORS 743.730 must submit to the Director of the Department of Consumer and Business Services:

(a) Upon request by the director, the methodology used to determine the insurer's allowable charges for out-of-network procedures and services or, if the insurer uses a third party to determine the charges, the methodology used by the third party to determine allowable charges;

(b) For approval, a written explanation of the method used by the insurer to determine the allowable charge, that is in plain language and that must be provided upon request to enrollees directly, or, in the case of group coverage, to the employer or other policyholder for distribution to enrollees; and

(c) Information prescribed by the director as necessary to assess the effect of the disclosure requirements in sections 2 and 3 of this 2007 Act on the individual and group health insurance markets.

(2) The director shall consider the recommendations of the Health Insurance Reform Advisory Committee in prescribing the information required for submission under subsection (1)(c) of this section.

SECTION 5. The Director of the Department of Consumer and Business Services may waive the requirements of section 2 or 3 of this 2007 Act to allow an insurer to use an alternative disclosure mechanism, provided that the mechanism enables enrollees to access information substantially similar to or more extensive than the information disclosed in section 2 or 3 of this 2007 Act.

SECTION 6. The Director of the Department of Consumer and Business Services shall adopt rules necessary to carry out the purposes of sections 1 to 6 of this 2007 Act.

SECTION 7. Sections 2 and 3 of this 2007 Act become operative on July 1, 2009.

Passed by House March 21, 2007

Repassed by House June 4, 2007

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Chief Clerk of House

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Speaker of House

Passed by Senate May 31, 2007

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President of Senate

Received by Governor:

.....M.,....., 2007

Approved:

.....M.,....., 2007

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Governor

Filed in Office of Secretary of State:

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Secretary of State