HB 2339 STAFF MEASURE SUMMARY

Senate Committee On Health Care

Prepared By: Oliver Droppers, LPRO Analyst
Meeting Dates: 4/27, 5/18

WHAT THE MEASURE DOES:

Prohibits non-participating, facility-based providers and providers in emergency cases from balance billing. Requires insurers to pay non-participating, facility-based providers a reasonable and customary payment rate. Specifies that the reimbursement formula for non-emergency services equals 175 percent of the amount paid by Medicare. Specifies the criteria to be used to establish reimbursement formula for emergency services. Adds definitions for enrollee, facility-based provider, participating and provider. Sections 2-5 take effect on January 1, 2019. Declares emergency, effective on passage.

REVENUE: No revenue impact.
*FISCAL: Has minimal fiscal impac*t.

ISSUES DISCUSSED:

- Potential violations and enforcement ability by DCBS
- Use of FAIR Health Inc.
- Concerns about linking reimbursement (i.e., provider payments) to Medicare compared to usual and customary rates
- Consumer choice and ability to navigate in-network vs. out-of-network service providers
- Contracted (i.e., negotiated rates) vs. non-contracted rates among insurers and health care providers
- Concerns about overall impact to Oregon's provider and insurer contracting process including incentives among insurers to negotiate and enter contracts with providers
- Other states that prohibit balance billing
- Emergency medical transport services
- Proposed amendment

EFFECT OF AMENDMENT:

BACKGROUND:

Health insurers contract with providers, hospitals and other medical professionals to participate in a network designed to deliver care to individuals enrolled in a health plan, referred to as a provider network. Through this process, insurers negotiate rates with providers to control costs and offer lower premiums to consumers. As the federal Affordable Care Act (ACA) was implemented, insurers, particularly those offering plans on the new marketplace, turned to the use of limited networks (or narrow networks). Narrow networks offer consumers a limited choice of providers for hospital and ambulatory services. This trend serves as a contributing factor in the wide variation in hospital and physician payment rates for in-network and out-of-network plans often found in a single geographic region (e.g. city or county).

Surprise or balance billing is a growing trend in the U.S. that involves the practice of billing the difference between a provider's charge and the allowed amount (the most an insurance company will pay for covered medical care). This happens when a patient receives a higher-than-expected bill that is discovered by the patient after the service is performed, leaving the patient unable to seek relief from unanticipated charges. For example, an individual may receive emergency services in a hospital that is in the health plan's provider network, but the actual professional providing the services is an out-of-network provider. Similarly, an enrollee may be unable to obtain services from an in-network health care provider and seek care from an out-of-network provider. If the provider is out-of-network, the

enrollee's health insurance plan issuer may pay only a portion of the out-of-network provider's charge, and the provider can opt to bill the enrollee for the balance.

In the past few years, dozens of states have introduced and enacted legislation to create consumer protections by capping or limiting charges for services delivered out-of-network. Approaches states have taken range from improving consumer notification, disclosure and transparency requirements, billing dispute resolution, prohibiting balance billing and setting cost limits on out-of-network providers.

In Oregon, between 2014 and 2016, the Department of Consumer and Business Services closed more than 300 complaints related to balance billing. House Bill 2339-A prohibits providers and health care facilities from balance billing. Requires health plans to reimburse out-of-network providers using specified rates.