House Bill 3333

Sponsored by Representative HACK; Representative ESQUIVEL

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 **as introduced.**

Requires insurers and third party administrators to pay claims for out-of-network health services within 30 days and according to standards identified by Department of Consumer and Business Services. Prohibits balance billing by clinicians for out-of-network services. Requires department to offer mediation procedure for clinicians and guarantors to dispute amount of reimbursement paid for out-of-network services.

A BILL FOR AN ACT

Relating to health insurance claims for out-of-network health services.

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

SECTION 1. Sections 2 and 3 of this 2017 Act are added to and made a part of the Insurance Code.

SECTION 2. (1) As used in this section and section 3 of this 2017 Act:

(a) "Balance bill" or "balance billing" means sending a bill to a guarantor for the difference between a clinician's usual and customary charge and the amount of reimbursement paid by an insurance carrier in accordance with this section for health services provided by the clinician to a patient.

(b) "Clinician" means:

(A) A physician as defined in ORS 677.010.

(B) An advanced practice registered nurse as described in ORS 678.025.

(C) A physician assistant licensed under ORS 677.505 to 677.525.

(D) A licensed registered nurse certified by the Oregon State Board of Nursing as a nurse midwife nurse practitioner.

(c) "Guarantor" means a person who is financially responsible for the cost of health services provided to a patient. The guarantor may also be the patient.

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

(e) "Health services" means professional services provided by a clinician for which reimbursement is available, if offered by an in-network clinician, under the terms of a health insurance policy, certificate or contract.

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

(g) "Insurance carrier" means:

(A) A person with a certificate of authority to transact insurance that offers a health benefit plan in this state.

(B) A third party administrator licensed under ORS 744.702.

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

(i) "Out-of-network allowed charge" means the amount of reimbursement paid by an insurance carrier for specified out-of-network health services.

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.

(j) "Share of the cost" means copayments, coinsurance and deductibles that a guarantor is required to pay for health services under the terms of a health insurance policy, certificate or contract.

(k) "Usual and customary charge" means the amount routinely billed by a clinician for professional services before any discounts or contractual adjustments.

(2) If a clinician submits a claim for reimbursement to an insurance carrier for out-of-network health services provided to a patient who is enrolled in a plan offered by the insurance carrier:

(a) No later than 30 calendar days after the clinician submits the claim, the insurance carrier shall reimburse the clinician directly for the health services, as coded and billed by the clinician;

(b) The reimbursement of the claim must include the guarantor's share of the cost of the health services; and

(c) The amount of any deductible paid to a clinician under paragraph (b) of this subsection must be applied to the guarantor's deductible for out-of-network health services.

(3) The Department of Consumer and Business Services shall identify a database of usual and customary charges that is maintained by an independent nonprofit organization that is not affiliated with or financially supported or endorsed by an insurance carrier. An insurance carrier must reimburse claims for out-of-network health services at no less than the 80th percentile of the charges reported in the database for clinicians providing such services in the geographic area where the health services were provided.

(4) Subsection (2) of this section does not prohibit an insurance carrier from billing a guarantor for the guarantor's share of the cost for health services that the insurance carrier pays to the clinician.

(5) An insurance carrier may not communicate to a guarantor or include in an explanation of benefits false, misleading or confusing information regarding:

(a) Usual and customary charges;

(b) Balance billing; or

(c) A mediation involving a clinician and the insurance carrier.

SECTION 3. (1) The Department of Consumer and Business Services shall make available to clinicians and guarantors a mediation procedure to resolve any dispute regarding an insurance carrier's reimbursement of out-of-network health services under section 2 of this 2017 Act if the amount in dispute is at least $500 after deducting the insurance carrier's out-of-network allowed charge and the guarantor's share of the cost of the health service.

(2) A clinician may request mediation if the clinician believes that the reimbursement paid in accordance with section 2 of this 2017 Act does not properly recognize:

(a) The clinician's training, qualifications and length of time in practice;

(b) The clinician's usual and customary charges;

(c) The usual and customary charges for clinicians practicing in the same geographic area; or

(d) Other aspects of the clinician's practice that may be relevant to the value of the clinician's out-of-network health services.

(3) A guarantor or clinician may initiate mediation by providing written notice of the dispute to the insurance carrier and the department. The department may designate an independent third party to conduct the mediation.

(4) The department or the department's designee shall resolve the dispute no later than 30 days after the department or the designee receives the written notice described in subsection (3) of this section.

(5) Clinicians may consolidate similar claims or claims presenting common issues for adjudication in one mediation to promote speedy dispute resolutions.

(6) The department or the department's designee adjudicating the mediation must resolve the dispute by selecting one of the proposals offered by the parties to the mediation. The department or the department's designee may not:

(a) Establish a reimbursement rate other than the rates proposed by the parties; or

(b) Take into account the fee schedule for payments by Medicare published by the Centers for Medicare and Medicaid Services.

(7) A guarantor or clinician who pursues mediation under this section retains all rights under existing law to file complaints with the department if the complaint:

(a) Involves an amount billed for a health service that is less than $500 after deducting the insurance carrier's out-of-network allowed charge and the guarantor's share of the cost of the health service; or

(b) Alleges regulatory noncompliance by the insurance carrier.

(8) The department or the department's designee may deny a clinician a right to mediation under this section if the department or the designee determines that the clinician has engaged in a pattern of balance billing guarantors in violation of section 4 of this 2017 Act.

SECTION 4. (1) As used in this section:

(a) "Balance bill" has the meaning given that term in section 2 of this 2017 Act.

(b) "Clinician" has the meaning given that term in section 2 of this 2017 Act.

(c) "Guarantor" has the meaning given that term in section 2 of this 2017 Act.

(d) "Insurance carrier" has the meaning given that term in section 2 of this 2017 Act.

(e) "Out-of-network health services" has the meaning described in section 2 of this 2017 Act.

(2) Reimbursement paid to a clinician for out-of-network health services by an insurance carrier in accordance with sections 2 and 3 of this 2017 Act shall be considered payment in full for the cost of health services provided by the clinician and the clinician may not balance bill the guarantor.

(3) A guarantor has a cause of action for damages caused by a violation of this section.

SECTION 5. Sections 2 and 4 of this 2017 Act apply to charges for health services provided by a clinician on or after the effective date of this 2017 Act.