

**B-Engrossed**  
**House Bill 2213**

Ordered by the Senate May 25  
Including House Amendments dated March 16 and Senate Amendments  
dated May 25

Ordered printed by the Speaker pursuant to House Rule 12.00A (5). Pre-session filed (at the request of Governor Theodore R. Kulongoski for Department of Consumer and Business Services)

**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 insurer offering health benefit plan to establish procedures for providing to enrollee reasonable estimate of enrollee's costs for certain procedures or services. Requires insurer to submit to Director of Department of Consumer and Business Services, *[for director's approval]* **upon director's request**, insurer's methodology to implement disclosure requirements.

**A BILL FOR AN ACT**

1  
2 Relating to payments for procedures covered by health benefit plan.

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

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

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

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

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

14 (a) **The type of procedure or service;**

15 (b) **The name of the provider;**

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

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

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

20 (a) **The enrollee's deductible;**

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

22 (c) **Coinsurance, copayment or other cost share to be paid by the enrollee for the proce-**  
23 **dure or service; and**

24 (d) **Any applicable benefit maximum.**

25 (3) **Subsections (1) and (2) of this section apply to the insurer's five most common pro-**  
26 **cedures or services within each of the following categories:**

**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.

- 1 (a) Office visits;
- 2 (b) Diagnostic radiology and imaging;
- 3 (c) Diagnostic pathology and laboratory procedures;
- 4 (d) Normal vaginal delivery;
- 5 (e) Immunizations;
- 6 (f) Orthopedic-musculoskeletal surgery; and
- 7 (g) Digestive system endoscopy.

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

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

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

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

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

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

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

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

- 31 (a) The type of procedure or service;
- 32 (b) The name of the provider;
- 33 (c) The enrollee's member number or policy number;
- 34 (d) If requested by the insurer, the site where the procedure or service will be performed;

35 and

- 36 (e) The provider's billed charge amount.

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

- 39 (a) The enrollee's deductible;
- 40 (b) The amount of the deductible that has been met by processed claims;
- 41 (c) Coinsurance, copayment or other cost share to be paid by the enrollee for the proce-  
42 dure or service;
- 43 (d) Any applicable benefit maximum;
- 44 (e) The difference between the insurer's allowable charge and the billed charge for the  
45 procedure or service; and

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

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

- 5 (a) Office visits;
- 6 (b) Diagnostic radiology and imaging;
- 7 (c) Diagnostic pathology and laboratory procedures;
- 8 (d) Normal vaginal delivery;
- 9 (e) Immunizations;
- 10 (f) Orthopedic-musculoskeletal surgery; and
- 11 (g) Digestive system endoscopy.

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

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

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

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

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

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

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

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

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

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

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

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

45 **SECTION 5.** The Director of the Department of Consumer and Business Services may

1 waive the requirements of section 2 or 3 of this 2007 Act to allow an insurer to use an al-  
2 ternative disclosure mechanism, provided that the mechanism enables enrollees to access  
3 information substantially similar to or more extensive than the information disclosed in  
4 section 2 or 3 of this 2007 Act.

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

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