Senate Bill 437

Sponsored by Senator STEINER HAYWARD; Senator SHIELDS, Representative REARDON (Presession filed.)

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 insurer to reimburse out-of-network providers of emergency services at prescribed rates. Requires in-network health care facility to notify enrollee if services will be provided by out-of-network providers and of estimated costs of services provided by out-of-network providers.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to out-of-network health care providers; and declaring an emergency.

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

SECTION 1. Section 2 of this 2013 Act is added to and made a part of the Insurance Code.

SECTION 2. (1) As used in this section:

(a) "Emergency services" has the meaning given that term in ORS 743A.012.

(b) "Health care facility" has the meaning given that term in ORS 442.015.

(c) "In-network" means a health care provider has a medical services contract with an insurer to provide health services to enrollees in health benefit plans offered by the insurer.

(d) "Nonemergency" means a patient's life or health would not be jeopardized by delaying treatment until a disclosure required by subsection (4) of this section is made.

(e) "Out-of-network" means a health care provider does not have a medical services contract with an insurer to provide health services to enrollees in health benefit plans offered by the insurer.

(f) "Timely" means soon enough to allow an enrollee to evaluate cost information before treatment is initiated.

(2) An insurer shall reimburse an out-of-network provider for emergency services at the greater of the following amounts:

(a) The rate paid to in-network providers for the emergency services, less the copayment or coinsurance amount imposed on the enrollee for in-network services. If the insurer pays different rates to different in-network providers for the same service, the insurer shall pay the median of all of the rates, less the copayment or coinsurance amount imposed on the enrollee for in-network services.

(b) The rate paid to out-of-network providers for the emergency services, less the copayment or coinsurance amount imposed on the enrollee for in-network services.

(c) The Medicare rate for the emergency services, less any copayment or coinsurance amount imposed on the enrollee for in-network services.

(3)(a) A provider may not bill an enrollee for the difference between reimbursement calculated in accordance with subsection (2) of this section and the usual and customary charge of the provider for the emergency 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.

(b) If the emergency services are provided at an in-network health care facility, a provider may bill the facility for the difference between the reimbursement calculated in accordance with subsection (2) of this section and the usual and customary charge of the provider for the emergency services.

(4) A health care facility that is an in-network provider for an insurer shall, with respect to an enrollee in a health benefit plan offered by the insurer:

(a) Provide all nonemergency services using only in-network providers; or

(b) If the health care facility cannot provide all nonemergency services using only in-network providers, timely notify the enrollee:

(A) That specified services will be provided by out-of-network providers;

(B) Of the estimated out-of-pocket costs to the enrollee of the services to be provided by out-of-network providers; and

(C) Of the enrollee's right to decline the services to be provided by out-of-network providers.

(5) A health care facility shall report to the Department of Consumer and Business Services all notices made under subsection (4)(b) of this section within five business days of the date the enrollee was notified. The facility shall exclude protected health information from the report and shall include:

(a) A description of each service that the health care facility was unable to provide using in-network providers;

(b) The name of the insurer; and

(c) Any other information prescribed by the department by rule.

SECTION 3. Section 2 of this 2013 Act applies to health benefit plans issued or renewed on or after the effective date of this 2013 Act.

SECTION 4. This 2013 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2013 Act takes effect on its passage.