Corrected

HB 2339 B STAFF MEASURE SUMMARY

Carrier: Sen. Kruse

Senate Committee On Health Care

Action Date:	05/30/17
Action:	Do pass with amendments to the A-Eng bill. (Printed B-Eng.)
Vote:	5-0-0-0
Yeas:	5 - Beyer, Knopp, Kruse, Monnes Anderson, Steiner Hayward
Fiscal:	Has minimal fiscal impact
Revenue:	No revenue impact
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WHAT THE MEASURE DOES:

Prohibits non-participating, facility-based providers and providers in emergency cases from balance billing. Requires the Department of Consumer and Business Services (DCBS) to develop recommendations for reimbursement of services provided to enrollees by out-of-network providers at health care facilities that are in-network. Requires DCBS to submit recommendations to Legislative Assembly no later than December 31, 2017. Declares emergency, effective on passage.

ISSUES DISCUSSED:

- Potential violations and enforcement ability of Department of Consumers and Business Services (DCBS)
- Use of FAIR Health Inc.
- Reasonableness of proposed benchmark reimbursement rate; concerns about linking reimbursement (i.e., provider payments) to Medicare compared to usual and customary rate
- Consumer choice and ability to navigate in-network versus out-of-network service 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 services transportation

EFFECT OF AMENDMENT:

Prohibits balance billing. Requires DCBS to develop recommendations for reimbursement of services provided to enrollees by out-of-network providers at health care facilities that are in-network

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 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 after a service is performed, leaving the patient unable to seek relief from unanticipated charges. For example, an individual may receive emergency services in a hospital within 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, 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 include 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 (DCBS) closed more than 300 complaints related to balance billing.

House Bill 2339-B prohibits out-of-network providers from balance billing insured patients and requires DCBS to develop recommendations for reimbursement of services provided to enrollees by out-of-network providers.