DCBS | Consumer and Business Services

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OREGON DIVISION OF FINANCIAL REGULATION BULLETIN No. DFR 2018–02

TO: All Entities Transacting Insurance in Oregon; All Health Care Providers Contracting with Entities Transacting Insurance in Oregon

RE: Implementation of Balance Billing Legislation, 2017 HB 2339 and 2018 SB 1549

Purpose:

The purpose of this bulletin is to clarify the Department of Consumer and Business Services (DCBS), Division of Financial Regulation's (DFR) supervisory expectations with respect to Oregon's balance billing laws and the implementation of reimbursement methods established by the Legislative Assembly.

Authority:

- 2017 Or Laws ch 417 (Enrolled House Bill 2339)
- ORS 743B.287
- 2018 Or Laws ch 43, § 4 (Enrolled Senate Bill 1549)

Explanation of terms used in this bulletin:

- "All-Payer, All-Claims Database" or "APAC" means the collection of data gathered by the Oregon Health Authority under ORS 442.466 to inform consumers on, among other things, the prices and quality of health care services.
- "CPT" means Current Procedural Terminology, a proprietary system owned by the American Medical Association to note a particular treatment for billing purposes.

Discussion

1. *Operative Date of Balance Billing Ban*. Section 2 of 2017 Or Laws ch 417 prohibits a provider from billing a consumer who receives out-of-network services rendered in an in-network facility. It also requires an out-of-network provider to inform the consumer of out-of-pocket expenses if the consumer chooses to receive services from that provider. Together, these two provisions prohibit a surprise billing situation where the consumer incurs unknown out-of-pocket costs without first agreeing to the service.

   Both the balance billing ban and the provider's duty to inform are effective for all patient interactions that occur on or after March 1, 2018. For example, a person treated by an out-of-network provider at 11:40 pm on February 28, 2018, may still

receive a balance bill for the treatment. However, a person treated at midnight or after on March 1, 2018, may not receive a balance bill.

2. *All-Payer, All-Claims Data.* ORS 743B.287, as amended by enrolled Senate Bill 1549, directs DCBS to set by rule the reimbursement benchmark for balance billing. The rulemaking process will require stakeholder input from providers, insurers, consumer advocates, and other interested parties. Until this work can be completed, all requests for data should flow through the workgroup process, and structured data use agreements negotiated between DCBS and the Oregon Health Authority.

3. *Interim Contract Negotiation.* Until DCBS adopts rules establishing reimbursement parameters, insurers and providers will need to negotiate on reimbursement rates for emergency services provided at an out-of-network health care facility. Negotiated rates must otherwise conform with 2018 Or Laws ch 43, § 4.

4. *Verifying Consumer Choice.* The ban on balance billing under ORS 743B.287 provides an exception if a consumer chooses to receive care from an out-of-network provider in an in-network setting. In order for the exception to apply, the choice must be meaningful and documented. A provider may not bill a consumer who receives out-of-network services rendered in an in-network facility unless:

    a. The consumer had a reasonable alternative to the out-of-networks service;
    b. The consumer was informed of the alternative to the out-of-network service;
    c. The consumer was informed of the out-of-pocket cost of the out-of-network service;
    d. The consumer provided informed consent to the out-of-network service; and
    e. The consumer's choice is documented.

    If there is no evidence that consumer consented to receive the service, the ban applies and the reimbursement rate set in statute controls.

As implementation of the balance billing/reimbursement laws continues, the department may update this bulletin or issue new guidance, as appropriate.

Director's expectations for insurers and other regulated entities

Based on the foregoing discussion, it is the director's expectations that:

1. Patients treated on or after March 1, 2018, will not be balance billed for out-of-network care in an in-network facility.
2. All requests for APAC data will flow through the advisory committee process
3. From March 1, 2018 until such time as DCBS can adopt required rules, insurers and providers should negotiate on reimbursement rates consistent with the provisions of 2018 Or Laws ch 43, § 4.

4. Consumers must be provided a reasonable opportunity to choose whether they will receive care from an out-of-network provider, to the extent that circumstances allow for free and voluntary choice.

This bulletin takes effect 4/9/2018.

Dated this 9th day of April, 2018 at Salem, Oregon.

Andrew Stolfi
Oregon Insurance Commissioner
Administrator, Division of Financial Regulation