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NOTICE OF PROPOSED RULEMAKING
INCLUDING STATEMENT OF NEED & FISCAL IMPACT

CHAPTER 836
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
INSURANCE REGULATION

FILED
08/27/2024 1:36 PM
ARCHIVES DIVISION
SECRETARY OF STATE

FILING CAPTION: Repealing rules for calculating out-of-network provider reimbursement rates and prevent enrollee balance billing.

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 10/02/2024 5:00 PM

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

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350 Winter St. NE
Salem,OR 97301

Filed By:
Karen Winkel
Rules Coordinator

HEARING(S)

Auxiliary aids for persons with disabilities are available upon advance request. Notify the contact listed above.

DATE: 09/25/2024
TIME: 1:30 PM - 2:00 PM
OFFICER: Lisa Emerson

IN-PERSON HEARING DETAILS
ADDRESS: Labor and Industries Building, 350 Winter St. NE, Basement, Conf Rm E , Salem, OR 97301

REMOTE HEARING DETAILS
MEETING URL: Click here to join the meeting
PHONE NUMBER: 503-446-4951
CONFERENCE ID: 402387968
SPECIAL INSTRUCTIONS:
This is a hybrid meeting conducted in-person and virtually via Microsoft Teams:
Meeting ID: 210 717 012 410
Passcode: 9EcoUv

NEED FOR THE RULE(S)

ORS 743B.287, as amended by SB 1549 (2018), requires an insurer offering a health benefit plan and a health care service contractor to reimburse an out-of-network provider for emergency services or other covered inpatient or outpatient services provided at an in-network health care facility. A provider who is an out-of-network provider may not balance bill an enrollee in the health benefit plan or health care service contract for emergency services or other inpatient or outpatient services provided at an in-network health care facility. If an enrollee chooses to receive services from an out-of-network provider, the provider shall inform the enrollee that the enrollee will be financially responsible for coinsurance, copayments or other out-of-pocket expenses attributable to choosing an out-of-network provider.

SB 1549 (2018) Section 4 (6) provided DCBS with the authority to adopt rules for calculating out-of-network provider reimbursement rates and prevent enrollee balance billing. Section 6 of the bill amended Section 4 (6), and repealed DCBS's authority to adopt rules for calculating out-of-network provider reimbursement rates, thus sunset the rules for calculating out-of-network provider reimbursement. Section 7 (2) of the bill set a Section 6 amendment effective date of January 2, 2022.

Therefore, the department must repeal OARs 836-053-1600, 836-053-1605, 836-053-1610, and 836-053-1615 because the statutory authority for their enactment expired January 2, 2022.

On January 1, 2022, the Federal No Surprises Act (2020) Independent Dispute Resolution (IDR) process went into effect for insurers and providers to follow to determine the health insurance reimbursement rate amount to be paid to out-of-network providers for emergency services or other covered inpatient or outpatient services provided at certain in-network health care facilities and prevents enrollee balance billing.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE

Draft rules are available from Karen Winkel, Rules Coordinator, Division of Financial Regulation located at 350 Winter St. NE, Salem, OR 97301 and are available on the division's website: https://dfr.oregon.gov/laws-rules/Pages/proposed-rules.aspx.

STATEMENT IDENTIFYING HOW ADOPTION OF RULE(S) WILL AFFECT RACIAL EQUITY IN THIS STATE

The department must repeal OARs 836-053-1600, 836-053-1605, 836-053-1610, and 836-053-1615 because the statutory authority for their enactment expired January 2, 2022. The proposed repeal of these rules will not affect DCBS's operations. Instead, the repeal of the rules will remove obsolete, non-operational rules. Effective 1/1/2022, the federal No Surprises Act provisions for determining out-of-network provider reimbursement and prevention of enrollee balance billing provides protection of all groups of people covered by the law.

FISCAL AND ECONOMIC IMPACT:

The proposed repeal of these rules will not have any effect on DCBS's operations and will have no fiscal or economic impact on small business. Based on financial filings made to DFR, no insurers meet the definition of a small business under ORS 183.310, because no insurer is independently owned and operated. This rule change merely removes non-operational language from the administrative rules, thereby harmonizing it with the applicable statute.

COST OF COMPLIANCE:

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

(1) Based on information currently available to DCBS, the proposed repeal of these rules will not have a fiscal or economic impact on state agencies, local government units, nor the public.

(2)(a) The rules being repealed applied solely to health insurance carriers. Based on financial filings made to DFR, no insurers meet the definition of a small business under ORS 183.310, because no insurer is independently owned and operated.

(2)(b) The proposed rulemaking would repeal obsolete requirements and is not expected to have any impact on

compliance costs for health insurance carriers.

(2)(c) The proposed rulemaking would repeal obsolete requirements and is not expected to have any impact on compliance costs for health insurance carriers.

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

The department must repeal OARs 836-053-1600, 836-053-1605, 836-053-1610, and 836-053-1615 because the statutory authority for their enactment expired January 2, 2022. Since the repeal of these obsolete rules is not expected to have any impact on small businesses or other stakeholders, the division has not solicited feedback from stakeholders in advance of this notice.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:
836-053-1600, 836-053-1605, 836-053-1610, 836-053-1615

REPEAL: 836-053-1600

RULE SUMMARY: Repealed because the statutory authority for their enactment expired January 2, 2022.

CHANGES TO RULE:

~~836-053-1600~~
~~Purpose; Statutory Authority; Applicability~~
~~(1) 836-053-1600 to 836-053-1615 are adopted for the purpose of implementing ORS 743B.287.¶~~
~~(2) 836-053-1600 to 836-053-1615 apply to payments required under ORS 743B.287(6).~~
~~Statutory/Other Authority: ORS 743B.287~~
~~Statutes/Other Implemented: ORS 743B.287~~

REPEAL: 836-053-1605

RULE SUMMARY: Repealed because the statutory authority for their enactment expired January 2, 2022.

CHANGES TO RULE:

~~836-053-1605~~
~~Definitions for 836-053-1600 to 836-053-1615~~
~~(1) "Anesthesia Conversion factor" means the dollar value assigned to the following geographic rating area where the procedure is performed:¶~~
~~(a) Area 1 is $68.00;¶~~
~~(b) Area 2 is $70.40;¶~~
~~(c) Area 3 is $67.85;¶~~
~~(d) Area 4 is $75.88;¶~~
~~(e) Area 5 is $68.00;¶~~
~~(f) Area 6 is $66.17; and¶~~
~~(g) Area 7 is $70.77.¶~~
~~(2) "Base units" means the number of units assigned to the relevant CPT code for the anesthesia-related procedure published in the American Society of Anesthesiologists (ASA), Relative Value Guide 2018. To obtain a copy of the ASA Relative Value Guide 2018, contact the American Society of Anesthesiologists, 1061 American Lane, Schaumberg, IL 60173, 847-825-5586, or www.asahq.org.¶~~
~~(3) "Base Rate" means the dollar amount listed on the Non-Anesthesia Base Rate Fee Schedule under Appendix A.¶~~
~~(4) "CMS" means the Center for Medicare and Medicaid Services.¶~~
~~(5) "CPT" means Current Procedural Terminology codes and terminology under the American Medical Association's (AMA) Current Procedural Terminology (CPT 2018), Fourth Edition Revised, 2017, for billing by medical providers. ¶~~
~~(6) "CPI adjustment" means the annual adjustment designated by the director calculated with the Consumer Price Index for All Urban Consumers U.S. city average series for all items, not seasonally adjusted. Prior to January 1 of each year the director shall publish the adjustment figure representing the Consumer Price Index adjustment from January 2015 to July of the prior year. For 2019, the designated CPI adjustment is 107.83%.¶~~
~~(7) "Director" means the Director of the Department of Consumer and Business Services.¶~~
~~(8) "Geographic rating area" means the rating area defined under OAR 836-053-0063(6).¶~~
~~(9) "Modifier adjustment" means the adjustment allowed under the CMS CY 2018 Physician Fee Schedule Final Rule as of January 1, 2018, for the following modifiers, if applicable: AS, FX, FY, SA, UE, 22, 23, 25, 47, 50, 51, 52, 53, 54, 55, 56, 62, 66, 73, 78, 80, 81, 82. The CY 2018 Physician Fee Schedule Final Rule is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1676-F.html. The adjustment for any other modifier or no modifier is 100%.¶~~
~~(10) "Out-of-network reimbursement" means the allowable rate paid by the insurer to the out-of-network provider for emergency services or other covered inpatient or outpatient services provided at an in-network health care facility in Oregon in accordance with ORS 743B.287(3). The amount to be paid by the insurer may include applicable coinsurance, copayment, and deductible amounts paid by the enrollee as outlined in the insurance policy.¶~~
~~(11) "Physical status units" means the number of units assigned based on the provider's assessment of the medical condition of the patient. Physical status units are assigned as follows:¶~~
~~(a) 1 unit for P3 - A patient with severe systemic disease;¶~~
~~(b) 2 units for P4 - A patient with severe systemic disease that is a constant threat to life;¶~~
~~(c) 3 units for P5 - A moribund patient who is not expected to survive without the operation; and¶~~
~~(d) 0 units for all others.¶~~
~~(12) "Q modifier adjustment" means the relevant percentage adjustment, if applicable, assigned for the following modifiers:¶~~
~~(a) 50% for QK - medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals;¶~~
~~(b) 50% for QX - CRNA service; with medical direction by a physician;¶~~
~~(c) 50% for QY - Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist; and¶~~
~~(d) 100% for no modifier or any other modifier.¶~~
~~(13) "Time units" means the relevant amount of time for an anesthesia-related procedure expressed in 15-minute increments.~~
~~Statutory/Other Authority: ORS 743B.287~~

~~Statutes/Other Implemented: ORS 743B.287~~

REPEAL: 836-053-1610

RULE SUMMARY: Repealed because the statutory authority for their enactment expired January 2, 2022.

CHANGES TO RULE:

~~836-053-1610~~
~~Non-anesthesia-related claims~~
~~(1) Out-of-network reimbursement for non-anesthesia-related claims shall be no less than:¶~~
~~Base rate x Modifier adjustment x CPI adjustment¶~~
~~(2) Out-of-network reimbursement for a non-anesthesia-related claim that does not have a base rate listed on the Non-Anesthesia Fee Schedule shall be at a rate agreed upon in good faith by the insurer and the provider to be usual and customary for in-network commercial claims, using best efforts to establish a rate within a reasonable amount of time.~~
~~Statutory/Other Authority: ORS 743B.287~~
~~Statutes/Other Implemented: ORS 743B.287~~

REPEAL: 836-053-1615

RULE SUMMARY: Repealed because the statutory authority for their enactment expired January 2, 2022.

CHANGES TO RULE:

~~836-053-1615~~
~~Anesthesia-related claims~~
~~(1) Out-of-network reimbursement for anesthesia-related claims, including obstetric anesthesia claims, shall be no less than:¶~~
~~(Base units + Time units + Physical status units) x Anesthesia Conversion factor x Q modifier adjustment x CPI adjustment¶~~
~~(2) Out-of-network reimbursement for an anesthesia-related claim that does not have a number of base units published in the CY 2018 Physician Fee Schedule Final Rule shall be reimbursed at a rate calculated with a number of base units agreed upon in good faith by the insurer and provider to be usual and customary for in-network commercial claims, using best efforts to establish a rate within a reasonable amount of time.~~
~~Statutory/Other Authority: ORS 743B.287~~
~~Statutes/Other Implemented: ORS 743B.287~~