§ 243.879. Provider reimbursement for hospital services or supplies; payment methods; application -- Oregon Educators Benefit Board

(1) A carrier that contracts with the Oregon Educators Benefit Board to provide to eligible employees and their dependents a benefit plan that reimburses the cost of inpatient or outpatient hospital services or supplies shall reimburse a claim for the cost of a hospital service or supply that is covered by, or is similar to a service or supply that is covered by, the Medicare program in an amount that does not exceed:

(a) For claims submitted by in-network hospitals, 200 percent of the amount paid by Medicare for the service or supply; or

(b) For claims submitted by out-of-network hospitals, 185 percent of the amount paid by Medicare for the service or supply.

(2) A self-insurance program administered by a third party administrator that is offered by the board to eligible employees and their dependents and that reimburses the cost of inpatient or outpatient hospital services or supplies shall reimburse a claim for the cost of a hospital service or supply that is covered by, or is similar to a service or supply that is covered by, the Medicare program in an amount that does not exceed:

(a) For claims submitted by in-network hospitals, 200 percent of the amount paid by Medicare for the service or supply; or

(b) For claims submitted by out-of-network hospitals, 185 percent of the amount paid by Medicare for the service or supply.

(3) A provider who is reimbursed in accordance with subsection (1) or (2) of this section may not charge to or collect from the patient or a person who is financially responsible for the patient an amount in addition to the reimbursement paid under subsection (1) or (2) of this section other than cost sharing amounts authorized by the terms of the health benefit plan.

(4) If a carrier or third party administrator does not reimburse claims on a fee-for-service basis, the payment method used must take into account the limits specified in subsections (1) and (2) of this section. Such payment methods include, but are not limited to:

(a) Value-based payments;

(b) Capitation payments; and

(c) Bundled payments.

(5) This section does not apply to reimbursements paid by a carrier or third party administrator to:

(a) A type A or type B hospital as described in ORS 442.470;

(b) A rural critical access hospital as defined in ORS 315.613;

(c) A hospital:

(A) Located in a county with a population of less than 70,000 on August 15, 2017;
(B) Classified as a sole community hospital by the Centers for Medicare and Medicaid Services; and
(C) With Medicare payments composing at least 40 percent of the hospital's total annual patient revenue; or
(d) A hospital located outside of this state.
(6) This section does not require a health benefit plan offered by the board to reimburse claims using a fee-for-service payment method.