Senate Bill 924

Sponsored by Senator BATES; Senator WESTLUND

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 health insurer to pay for specified health care services rendered by nonpreferred provider if covered for preferred provider. Requires health insurer to pay 95 percent of preferred provider payment rate to nonpreferred provider. Requires direct payment to nonpreferred provider with valid assignment of claim from enrollee.

Permits health insurer to impose copayment or deductible for services by nonpreferred providers if also imposed on services by preferred providers. Requires enrollee to pay copayment and deductible for nonpreferred provider.

Permits health insurer to impose same prior authorization and utilization control requirements on nonpreferred provider that are imposed on preferred provider.

Prohibits health insurers from leasing or renting health insurer's provider panels to other insurers in same service area.

A BILL FOR AN ACT

Relating to preferred provider organization insurance; creating new provisions; and amending ORS 743.801.

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

SECTION 1. It is the intent of the Legislative Assembly in enacting sections 1 to 4 of this 2007 Act to:

(1) Improve Oregon residents' access to health insurance and health care providers;

(2) Encourage fair and effective competition among health insurers;

(3) Prevent monopolistic practices; and

(4) Ensure that organizations offering health benefit plans within this state are financially and administratively sound and able to deliver benefits as promised.

SECTION 2. As used in sections 1 to 4 of this 2007 Act:

(1) "Clinical social worker" has the meaning given that term in ORS 675.510.

(2) "Dentist" has the meaning given that term in ORS 679.010.

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

(4) "Health insurer" means an entity offering managed health insurance, preferred provider organization insurance or coverage for health care services pursuant to a medical services contract, but does not include a health maintenance organization.

(5) "Health maintenance organization" has the meaning given that term in ORS 750.005.

(6) "Nurse practitioner" has the meaning given that term in ORS 678.010.

(7) "Preferred provider" means a provider who is under contract with or employed by a health insurer or who is part of a panel or network of providers under contract with or employed by a health insurer.

(8) "Physician" has the meaning given that term in ORS 677.010.

(9) "Physician assistant" has the meaning given that term in ORS 677.495.

(10) "Psychologist" means a person who engages in the practice of psychology as defined

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.

in ORS 675.010.

(11) "Specified health care services" means medical or mental health services provided by a physician, dentist, physician assistant, nurse practitioner, psychologist or clinical social worker licensed, certified or otherwise authorized or permitted by laws of this state to administer medical or mental health services in the ordinary course of business or practice of a profession.

SECTION 3. (1)(a) A health insurer shall pay for specified health care services provided to its enrollee by a provider who is not a preferred provider under the enrollee's health benefit plan, unless the specified health care services are not within the scope of services otherwise covered under the enrollee's health benefit plan.

(b) The payment under paragraph (a) of this subsection shall be equal to at least 95 percent of the amount paid by the health insurer to a preferred provider for the specified health care service.

(c) A health insurer shall make a payment under paragraph (a) of this subsection directly to a nonpreferred provider if the enrollee executes a valid assignment of the claim to the nonpreferred provider.

(2) A health insurer may:

(a) Require an enrollee to pay a copayment or deductible for medical treatment by a nonpreferred provider if the copayment or deductible is not greater than the copayment or deductible for the same medical treatment by a preferred provider under the enrollee's health benefit plan; or

(b) Impose prior authorization and other utilization control requirements for services rendered by nonpreferred providers if the prior authorization and utilization control requirements are the same as those imposed for services rendered by preferred providers under the enrollee's health benefit plan.

(3) A nonpreferred provider who accepts a payment under subsection (1) of this section may not collect from the enrollee any fees or expenses that exceed the amounts authorized in subsection (2) of this section.

(4) Except as provided under subsections (1) and (2) of this section, a health insurer may not:

(a) Restrict or in any way limit an enrollee's access to or choice of any willing provider of a specified health care service that is performed on an outpatient basis; or

(b) Create incentives, including but not limited to financial incentives or expanded coverage, to induce an enrollee to obtain specified health care services that are performed on an outpatient basis from a preferred provider or at a health care facility or other entity owned or operated by, or affiliated or associated with, the health insurer.

SECTION 4. A health insurer may not lease or rent the health insurer's preferred provider panel to other insurers offering health benefit plans within the geographic area where the health insurer currently offers insurance.

SECTION 5. ORS 743.801 is amended to read:

743.801. As used in ORS 743.699, 743.801, 743.803, 743.804, 743.806, 743.807, 743.808, 743.811, 743.814, 743.817, 743.819, 743.821, 743.823, 743.827, 743.829, 743.831, 743.834, 743.837, 743.839, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.866 and 743.868 **and sections 1 to 4 of this 2007 Act**:

(1) "Emergency medical condition" means a medical condition that manifests itself by acute

symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus in the case of a pregnant woman, in serious jeopardy.

(2) "Emergency medical screening exam" means the medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an emergency medical condition.

(3) "Emergency services" means those health care items and services furnished in an emergency department and all ancillary services routinely available to an emergency department to the extent they are required for the stabilization of a patient.

(4) "Enrollee" has the meaning given that term in ORS 743.730.

(5) "Grievance" means a written complaint submitted by or on behalf of an enrollee regarding the:

(a) Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(b) Claims payment, handling or reimbursement for health care services; or

(c) Matters pertaining to the contractual relationship between an enrollee and an insurer.

(6) "Health benefit plan" has the meaning provided for that term in ORS 743.730.

(7) "Independent practice association" means a corporation wholly owned by providers, or whose membership consists entirely of providers, formed for the sole purpose of contracting with insurers for the provision of health care services to enrollees, or with employers for the provision of health care services to employees, or with a group, as described in ORS 743.522, to provide health care services to group members.

(8) "Insurer" has the meaning provided for that term in ORS 731.106. For purposes of ORS 743.699, 743.801, 743.803, 743.804, 743.806, 743.807, 743.808, 743.811, 743.814, 743.817, 743.819, 743.821, 743.823, 743.827, 743.829, 743.831, 743.834, 743.837, 743.839, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.866, 743.868, 750.055 and 750.333, "insurer" also includes a health care service contractor as defined in ORS 750.005.

(9) "Managed health insurance" means any health benefit plan that:

(a) Requires an enrollee to use a specified network or networks of providers managed, owned, under contract with or employed by the insurer in order to receive benefits under the plan, except for emergency or other specified limited service; or

(b) In addition to the requirements of paragraph (a) of this subsection, offers a point-of-service provision that allows an enrollee to use providers outside of the specified network or networks at the option of the enrollee and receive a reduced level of benefits.

(10) "Medical services contract" means a contract between an insurer and an independent practice association, between an insurer and a provider, between an independent practice association and a provider or organization of providers, between medical or mental health clinics, and between a medical or mental health clinic and a provider to provide medical or mental health services. "Medical services contract" does not include a contract of employment or a contract creating legal entities and ownership thereof that are authorized under ORS chapter 58, 60 or 70, or other similar professional organizations permitted by statute.

(11)(a) "Preferred provider organization insurance" means any health benefit plan that:

(A) Specifies a preferred network of providers managed, owned or under contract with or employed by an insurer;

(B) Does not require an enrollee to use the preferred network of providers in order to receive benefits under the plan; and

(C) Creates financial incentives for an enrollee to use the preferred network of providers by providing an increased level of benefits.

(b) "Preferred provider organization insurance" does not mean a health benefit plan that has as its sole financial incentive a hold harmless provision under which providers in the preferred network agree to accept as payment in full the maximum allowable amounts that are specified in the medical services contracts.

(12) "Prior authorization" means a determination by an insurer prior to provision of services that the insurer will provide reimbursement for the services. "Prior authorization" does not include referral approval for evaluation and management services between providers.

(13) "Provider" means a person licensed, certified or otherwise authorized or permitted by laws of this state to administer medical or mental health services in the ordinary course of business or practice of a profession.

(14) "Stabilization" means that, within reasonable medical probability, no material deterioration of an emergency medical condition is likely to occur.

(15) "Utilization review" means a set of formal techniques used by an insurer or delegated by the insurer designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services, procedures or settings.

SECTION 6. Sections 1 to 4 of this 2007 Act and the amendments to ORS 743.801 made by section 5 of this 2007 Act apply to any specified health care services rendered on or after the effective date of this 2007 Act.