House Bill 2889

Sponsored by Representative MAURER

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.**

Prohibits insurer from requiring contract condition that precludes collection from patient for cost of health services not covered by medical services contract.

A BILL FOR AN ACT

Relating to payment for health care services; creating new provisions; amending ORS 735.650, 743.801, 743.803, 743.827, 743A.012, 750.005 and 750.035; and repealing ORS 743.821 and 750.095.

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

SECTION 1. ORS 743.803 is amended to read:

743.803. (1) A medical services contract may not require the provider, as an element of the contract or as a condition of compensation for services, to agree:

(a) In the event of alleged improper medical treatment of a patient, to indemnify the other party to the medical services contract for any damages, awards or liabilities including but not limited to judgments, settlements, attorney fees, court costs and any associated charges incurred for any reason other than the negligence or intentional act of the provider or the provider's employees;

(b) To charge the other party to the medical services contract a rate for services rendered pursuant to the medical services contract that is no greater than the lowest rate that the provider charges for the same service to any other person;

(c) To deny care to a patient because of a determination made pursuant to the medical services contract that the care is not covered or is experimental, or to deny referral of a patient to another provider for the provision of such care, if the patient is informed that the patient will be responsible for the payment of such noncovered, experimental or referral care and the patient nonetheless desires to obtain such care or referral; [*or*]

(d) Upon the provider's withdrawal from or termination or nonrenewal of the medical services contract, not to treat or solicit a patient even at that patient's request and expense[.]**; or**

(e) To waive collection of payment from a patient for services rendered if the services are not reimbursed under the contract.

(2) A medical services contract shall:

(a) Grant to the provider adequate notice and hearing procedures, or such other procedures as are fair to the provider under the circumstances, prior to termination or nonrenewal of the medical services contract when such termination or nonrenewal is based upon issues relating to the quality of patient care rendered by the provider.

(b) Set forth generally the criteria used by the other party to the medical services contract for the termination or nonrenewal of the medical services contract.

(c) Entitle the provider to an annual accounting accurately summarizing the financial trans-

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.

actions between the parties to the medical services contract for that year.

(d) Allow the provider to withdraw from the care of a patient when, in the professional judgment of the provider, it is in the best interest of the patient to do so.

(e) Provide that a doctor of medicine or osteopathy licensed under ORS chapter 677 shall be retained by the other party to the medical services contract and shall be responsible for all final medical and mental health decisions relating to coverage or payment made pursuant to the medical services contract.

(f) Provide that a physician who is practicing in conformity with ORS 677.095 may advocate a decision, policy or practice without being subject to termination or penalty for the sole reason of such advocacy.

(g)(A) Entitle the party to the medical services contract who is being reimbursed for the provision of health care services on a basis that includes financial risk withholds, or the party's representative, to a full accounting of health benefits claims data and related financial information on no less than a quarterly basis by the party to a medical service contract who has made reimbursement, as follows:

(i) The data shall include all pertinent information relating to the health care services provided, including related provider and patient information, reimbursements made and amounts withheld under the financial risk withhold provisions of the medical services contract for the period of time under reconciliation and settlement between the parties.

(ii) Any reconciliation and settlement undertaken pursuant to a medical services contract shall be based directly and exclusively upon data provided to the party who is being reimbursed for the provision of health care services.

(iii) All data, including supplemental information or documentation, necessary to finalize the reconciliation and settlement provisions of a medical services contract relating to financial risk withholds shall be provided to the party who is being reimbursed for the provision of health care services no later than 30 days prior to finalizing the reconciliation and settlement.

(B) Nothing in this paragraph shall be construed to prevent parties to a medical services contract from mutually agreeing to alternative reconciliation and settlement policies and procedures.

(h) Provide that when continuity of care is required to be provided under a health benefit plan by ORS 743.854, the insurer and the individual provider shall provide continuity of care to enrollees as provided in ORS 743.854.

(3) The other party to a medical services contract shall not:

(a) Refer to other documents or instruments in a contract unless the nonprovider party agrees to make available to the provider for review a copy of the documents or instruments within 72 hours of request; or

(b) Provide as an element of a contract with a third party relating to the provision of medical services to a patient of the provider that the provider's patient may not sue or otherwise recover from the nonprovider party, or must hold the nonprovider party harmless for, any and all expenses, damages, awards or liabilities that arise from the management decisions, utilization review provisions or other policies or determinations of the nonprovider party that have an impact on the provider's treatment decisions and actions with regard to the patient.

(4) An insurer, independent practice association, medical or mental health clinic or other party to a medical services contract shall provide the criteria for selection of parties to future medical services contracts upon the request of current or prospective parties.

SECTION 2. ORS 735.650 is amended to read:

735.650. (1) The following provisions of the Insurance Code shall apply to the pool to the extent applicable and not inconsistent with the express provisions of ORS 735.600 to 735.650: ORS 731.004 to 731.022, 731.052 to 731.146, 731.162, 731.216 to 731.328, 742.023, 742.028, 742.046, 742.051, 742.056, 743.024, 743.027, 743.028, 743.041, 743.050, 743.100 to 743.106, 743.402, 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, 743.834, 743.837, 743.839, 743.845, 743A.084, 743A.090, 746.005 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

(2) For the purposes of this section only, the pool shall be deemed an insurer, pool coverage shall be deemed individual health insurance and pool coverage contracts shall be deemed policies.

SECTION 3. ORS 743.801 is amended to read:

743.801. As used in ORS 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, 743.911[,] **and** 743.913 [*and 743A.012*]:

[*(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)*] **(1)** "Enrollee" has the meaning given that term in ORS 743.730.

[*(5)*] **(2)** "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)*] **(3)** "Health benefit plan" has the meaning [*provided for*] **given** that term in ORS 743.730.

[*(7)*] **(4)** "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)*] **(5)** "Insurer" has the meaning provided for that term in ORS 731.106. For purposes of ORS 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, 743.911, 743.913, 743A.012, 750.055 and 750.333, "insurer" also includes a health care service contractor as defined in ORS 750.005.

[*(9)*] **(6)** "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)*] **(7)** "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)*] **(8)(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)*] **(9)** "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)*] **(10)** "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)*] **(11)** "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 4. ORS 743.827 is amended to read:

743.827. The Director of the Department of Consumer and Business Services shall appoint a Health Care Consumer Protection Advisory Committee with fair representation of health care consumers, providers and insurers. The committee shall advise the director regarding the implementation of ORS 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 and 743A.012 and other issues related to health care consumer protection.

SECTION 5. ORS 743A.012 is amended to read:

743A.012. **(1) As used in this section:**

(a) "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.

(b) "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.

(c) "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.

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

(e) "Health benefit plan" has the meaning given that term in ORS 743.730.

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

[*(1)*] **(2)** All insurers offering a health benefit plan shall provide coverage without prior authorization for:

(a) Emergency medical screening exams;

(b) Stabilization of an emergency medical condition; and

(c) Emergency services provided by a nonparticipating provider if a prudent layperson possessing an average knowledge of health and medicine would reasonably believe that the time required to go to a participating provider would place the health of the person, or a fetus in the case of a pregnant woman, in serious jeopardy.

[*(2)*] **(3)** All insurers described in subsection [*(1)*] **(2)** of this section shall provide information to enrollees in plain language regarding:

(a) What constitutes an emergency medical condition;

(b) The coverage provided for emergency services;

(c) How and where to obtain emergency services; and

(d) The appropriate use of 9-1-1.

[*(3)*] **(4)** An insurer offering a health benefit plan may not discourage appropriate use of 9-1-1 and shall not deny coverage for emergency services solely because 9-1-1 was used.

[*(4)*] **(5)** This section is exempt from ORS 743A.001.

SECTION 6. ORS 750.005 is amended to read:

750.005. As used in ORS 750.005 to 750.095:

(1) "Claims" means any amount incurred by the insurer covering contracted benefits.

(2) "Complementary health services" means the following health care services:

(a) Chiropractic as defined in ORS 684.010;

(b) Naturopathic medicine as defined in ORS 685.010;

(c) Massage therapy as defined in ORS 687.011; or

(d) Acupuncture as defined in ORS 677.757.

(3) "Doctor" means any person lawfully licensed or authorized by statute to render any health care services.

(4) "Health care service contractor" means:

(a) Any corporation that is sponsored by or otherwise intimately connected with a group of doctors licensed by this state, or by a group of hospitals licensed by this state, or both, under contracts with groups of doctors or hospitals [*that include conditions holding the subscriber harmless in*

the event of nonpayment by the health care service contract as provided in ORS 750.095], and that accepts prepayment for health care services; or

(b) Any person referred to in ORS 750.035.

(5) "Health care services" means the furnishing of medicine, medical or surgical treatment, nursing, hospital service, dental service, optometrical service, complementary health services or any or all of the enumerated services or any other necessary services of like character, whether or not contingent upon sickness or personal injury, as well as the furnishing to any person of any and all other services and goods for the purpose of preventing, alleviating, curing or healing human illness, physical disability or injury.

(6) "Health maintenance organization" means any health care service contractor operated on a for-profit or not for-profit basis which:

(a) Qualifies under Title XIII of the Public Health Service Act; or

(b)(A) Provides or otherwise makes available to enrolled participants health care services, including at least the following basic health care services:

(i) Usual physician services;

(ii) Hospitalization;

(iii) Laboratory;

(iv) X-ray;

(v) Emergency and preventive services; and

(vi) Out-of-area coverage;

(B) Is compensated, except for copayments, for the provision of basic health care services listed in subparagraph (A) of this paragraph to enrolled participants on a predetermined periodic rate basis;

(C) Provides physicians' services primarily directly through physicians who are either employees or partners of such organization, or through arrangements with individual physicians or one or more groups of physicians organized on a group practice or individual practice basis; and

(D) Employs the terms "health maintenance organization" or "HMO" in its name, contracts, literature or advertising media on or before July 13, 1985.

SECTION 7. ORS 750.035 is amended to read:

750.035. (1) Notwithstanding any other provision of law, except as provided in subsection (2) of this section, any persons doing a hospital association business, as defined in ORS 742.010 (1959 Replacement Part) in compliance with ORS chapter 742 (1959 Replacement Part) on August 12, 1965, may continue such business in compliance with ORS chapter 742 (1959 Replacement Part).

(2) Every person doing a hospital association business, as defined in ORS 742.010 (1959 Replacement Part), on August 12, 1965, shall comply with the provisions of ORS 750.045, 750.055[,] **and** 750.085 [*and 750.095*].

SECTION 8. ORS 743.821 and 750.095 are repealed.

SECTION 9. The amendments to ORS 735.650, 743.801, 743.803, 743.827, 750.005 and 750.035 by sections 1 to 4, 6 and 7 of this 2009 Act and the repeal of ORS 743.821 and 750.095 by section 8 of this 2009 Act apply to medical services contracts with providers entered into or renewed on or after the effective date of this 2009 Act.