Senate Bill 850

Sponsored by COMMITTEE ON HEALTH CARE, HUMAN SERVICES AND RURAL HEALTH POLICY

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.**

Specifies minimum reimbursement rate for primary care practitioner services provided under health benefit plan or to medical assistance recipient.

A BILL FOR AN ACT

Relating to primary care reimbursement rates; creating new provisions; and amending ORS 743.801.

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

SECTION 1. Section 2 of this 2011 Act is added to and made a part of the Insurance Code.

SECTION 2. (1) As used in this section:

(a) "Primary care rate" means the rate established by the Oregon Health Authority under section 3 of this 2011 Act.

(b) "Relative value unit" means the value for a service that is established by the Centers for Medicare and Medicaid Services pursuant to 42 C.F.R. 414.22 and 414.24.

(2) All insurers offering a health benefit plan in this state shall reimburse primary care practitioners at a rate no less than the primary care rate multiplied by the relative value unit for the service.

SECTION 3. (1) As used in this section:

(a) "Relative value unit" means the value for a service that is established by the Centers for Medicare and Medicaid Services pursuant to 42 C.F.R. 414.22 and 414.24.

(b) "Prepaid managed care health services organization" has the meaning given that term in ORS 414.736.

(c) "Primary care practitioner" means:

(A) A nurse practitioner who is certified by the Oregon State Board of Nursing under ORS 678.375 and who is acting within the scope of practice for a nurse practitioner;

(B) A naturopathic physician licensed under ORS 685.020 who is acting within the scope of practice for a naturopathic physician; or

(C) A physician licensed under ORS chapter 677 whose specialty is family practice, general practice, internal medicine, pediatrics or obstetrics and gynecology.

(2) All primary care practitioners that provide services to medical assistance recipients and who are paid on a fee-for-service basis by the Oregon Health Authority or by a prepaid managed care health services organization shall be reimbursed an amount no less than the relative value unit for the service multiplied by 110 percent of the primary care rate.

(3) The primary care rate for 2012 is $75. Beginning in 2013, the Oregon Health Authority shall adjust the primary care rate annually using the increase or decrease in the cost of living for the previous calendar year, based on changes in the Portland-Salem, OR-WA Con-

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.

sumer Price Index for All Urban Consumers for All Items as published by the Bureau of Labor Statistics of the United States Department of Labor.

SECTION 4. Sections 2 and 3 of this 2011 Act apply to payments for services rendered by primary care practitioners under contracts or agreements with insurers or with the Oregon Health Authority that are entered into on or after the effective date of this 2011 Act.

SECTION 5. 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, 743.912, 743.913, 743.917, 743.918 and 743A.012 **and section 2 of this 2011 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 743.801, 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, 743.912, 743.913, 743.917, 743A.012, 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) "Primary care practitioner" means:

(a) A nurse practitioner who is certified by the Oregon State Board of Nursing under ORS 678.375 and who is acting within the scope of practice for a nurse practitioner;

(b) A naturopathic physician licensed under ORS 685.020 who is acting within the scope of practice for a naturopathic physician; or

(c) A physician licensed under ORS chapter 677 whose specialty is family practice, general practice, internal medicine, pediatrics or obstetrics and gynecology.

[*(12)*] **(13)** "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)*] **(14)** "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)*] **(15)** "Stabilization" means that, within reasonable medical probability, no material deterioration of an emergency medical condition is likely to occur.

[*(15)*] **(16)** "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.
