House Bill 2755

Sponsored by Representatives NOBLE, PRUSAK; Representative POST (at the request of Oregon Association of Acupuncturists) (Presession filed.)

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 restricting provider from allowing insured to pay provider directly for services instead of using insurance coverage.

A BILL FOR AN ACT

Relating to health insurance; creating new provisions; and amending ORS 743B.001.

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

SECTION 1. Section 2 of this 2021 Act is added to and made a part of the Insurance Code.

SECTION 2. (1) As used in this section, "self-pay" means an enrollee's voluntary choice to pay a provider directly for the cost of health care or services instead of the enrollee making a claim under a policy or certificate of health insurance to reimburse the cost of the care or services.

(2) Except as provided in ORS 743B.287, an insurer offering a policy or certificate of health insurance in this state may not, with respect to a provider who contracts with the insurer:

(a) Prohibit the provider from allowing an enrollee to self-pay;

(b) Dictate or restrict the amount, terms or method for self-pay; or

(c) Require the provider to report to the insurer the nature or price of services for which an enrollee chose to self-pay.

(3) This section does not apply to a covered service for which an enrollee chooses to self-pay if the provider has been reimbursed by the insurer in any amount for the service.

SECTION 3. ORS 743B.001 is amended to read:

743B.001. As used in this section and ORS 743.008, 743.029, 743.035, 743A.190, 743B.195, 743B.197, 743B.200, 743B.202, 743B.204, 743B.220, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.310, 743B.400, 743B.403, 743B.405, 743B.420, 743B.422, 743B.423, 743B.424, 743B.450, 743B.451, 743B.452, 743B.453, 743B.454, 743B.505, 743B.550 and 743B.555 and section 2, chapter 771, Oregon Laws 2013**, and section 2 of this 2021 Act**:

(1) "Adverse benefit determination" means an insurer's denial, reduction or termination of a health care item or service, or an insurer's failure or refusal to provide or to make a payment in whole or in part for a health care item or service, that is based on the insurer's:

(a) Denial of eligibility for or termination of enrollment in a health benefit plan;

(b) Rescission or cancellation of a policy or certificate;

(c) Imposition of a preexisting condition exclusion as defined in ORS 743B.005, source-of-injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or services;

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.

(d) Determination that a health care item or service is experimental, investigational or not medically necessary, effective or appropriate;

(e) Determination that a course or plan of treatment that an enrollee is undergoing is an active course of treatment for purposes of continuity of care under ORS 743B.225; or

(f) Denial, in whole or in part, of a request for prior authorization.

(2) "Authorized representative" means an individual who by law or by the consent of a person may act on behalf of the person.

(3) "Credit card" has the meaning given that term in 15 U.S.C. 1602.

(4) "Electronic funds transfer" has the meaning given that term in ORS 293.525.

(5) "Enrollee" has the meaning given that term in ORS 743B.005.

(6) "Essential community provider" has the meaning given that term in rules adopted by the Department of Consumer and Business Services consistent with the description of the term in 42 U.S.C. 18031 and the rules adopted by the United States Department of Health and Human Services, the United States Department of the Treasury or the United States Department of Labor to carry out 42 U.S.C. 18031.

(7) "Grievance" means:

(a) A communication from an enrollee or an authorized representative of an enrollee expressing dissatisfaction with an adverse benefit determination, without specifically declining any right to appeal or review, that is:

(A) In writing, for an internal appeal or an external review; or

(B) In writing or orally, for an expedited response described in ORS 743B.250 (2)(d) or an expedited external review; or

(b) A written complaint submitted by an enrollee or an authorized representative of an enrollee regarding the:

(A) Availability, delivery or quality of a health care service;

(B) Claims payment, handling or reimbursement for health care services and, unless the enrollee has not submitted a request for an internal appeal, the complaint is not disputing an adverse benefit determination; or

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

(8) "Health benefit plan" has the meaning given that term in ORS 743B.005.

(9) "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 731.098, to provide health care services to group members.

(10) "Insurer" includes a health care service contractor as defined in ORS 750.005.

(11) "Internal appeal" means a review by an insurer of an adverse benefit determination made by the insurer.

(12) "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.

(13) "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.

(14)(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.

(15) "Prior authorization" means a determination by an insurer upon request by a provider or an enrollee, prior to the provision of health care that is subject to utilization review, that the insurer will provide reimbursement for the health care requested. "Prior authorization" does not include referral approval for evaluation and management services between providers.

(16)(a) "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.

(b) With respect to the statutes governing the billing for or payment of claims, "provider" also includes an employee or other designee of the provider who has the responsibility for billing claims for reimbursement or receiving payments on claims.

(17) "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 items, services, procedures or settings.

SECTION 4. ORS 743B.001, as amended by section 12, chapter 284, Oregon Laws 2019, is amended to read:

743B.001. As used in this section and ORS 743.008, 743.029, 743.035, 743A.190, 743B.195, 743B.197, 743B.200, 743B.202, 743B.204, 743B.220, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.310, 743B.400, 743B.403, 743B.405, 743B.420, 743B.422, 743B.423, 743B.424, 743B.450, 743B.451, 743B.452, 743B.453, 743B.454, 743B.505, 743B.550 and 743B.555 **and section 2 of this 2021 Act**:

(1) "Adverse benefit determination" means an insurer's denial, reduction or termination of a health care item or service, or an insurer's failure or refusal to provide or to make a payment in whole or in part for a health care item or service, that is based on the insurer's:

(a) Denial of eligibility for or termination of enrollment in a health benefit plan;

(b) Rescission or cancellation of a policy or certificate;

(c) Imposition of a preexisting condition exclusion as defined in ORS 743B.005, source-of-injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or

services;

(d) Determination that a health care item or service is experimental, investigational or not medically necessary, effective or appropriate;

(e) Determination that a course or plan of treatment that an enrollee is undergoing is an active course of treatment for purposes of continuity of care under ORS 743B.225; or

(f) Denial, in whole or in part, of a request for prior authorization.

(2) "Authorized representative" means an individual who by law or by the consent of a person may act on behalf of the person.

(3) "Credit card" has the meaning given that term in 15 U.S.C. 1602.

(4) "Electronic funds transfer" has the meaning given that term in ORS 293.525.

(5) "Enrollee" has the meaning given that term in ORS 743B.005.

(6) "Essential community provider" has the meaning given that term in rules adopted by the Department of Consumer and Business Services consistent with the description of the term in 42 U.S.C. 18031 and the rules adopted by the United States Department of Health and Human Services, the United States Department of the Treasury or the United States Department of Labor to carry out 42 U.S.C. 18031.

(7) "Grievance" means:

(a) A communication from an enrollee or an authorized representative of an enrollee expressing dissatisfaction with an adverse benefit determination, without specifically declining any right to appeal or review, that is:

(A) In writing, for an internal appeal or an external review; or

(B) In writing or orally, for an expedited response described in ORS 743B.250 (2)(d) or an expedited external review; or

(b) A written complaint submitted by an enrollee or an authorized representative of an enrollee regarding the:

(A) Availability, delivery or quality of a health care service;

(B) Claims payment, handling or reimbursement for health care services and, unless the enrollee has not submitted a request for an internal appeal, the complaint is not disputing an adverse benefit determination; or

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

(8) "Health benefit plan" has the meaning given that term in ORS 743B.005.

(9) "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 731.098, to provide health care services to group members.

(10) "Insurer" includes a health care service contractor as defined in ORS 750.005.

(11) "Internal appeal" means a review by an insurer of an adverse benefit determination made by the insurer.

(12) "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.

(13) "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.

(14)(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.

(15) "Prior authorization" means a determination by an insurer upon request by a provider or an enrollee, prior to the provision of health care that is subject to utilization review, that the insurer will provide reimbursement for the health care requested. "Prior authorization" does not include referral approval for evaluation and management services between providers.

(16)(a) "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.

(b) With respect to the statutes governing the billing for or payment of claims, "provider" also includes an employee or other designee of the provider who has the responsibility for billing claims for reimbursement or receiving payments on claims.

(17) "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 items, services, procedures or settings.
