House Bill 3242

Sponsored by Representative DIEHL (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.** The statement includes a measure digest written in compliance with applicable readability standards.

Digest: This Act tells a health insurer to pay a health care provider in the same way it would pay if they were in-network during a certain time and in some situations. (Flesch Readability Score: 63.4).

Requires health insurers to pay providers who are joining an in-network practice the same as in-network providers during the credentialing period.

Takes effect on the 91st day following adjournment sine die.

A BILL FOR AN ACT

Relating to in-network credentialing; amending ORS 743B.454; and prescribing an effective date.

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

SECTION 1. ORS 743B.454 is amended to read:

743B.454. (1) As used in this section:

(a) "Complete application" means a provider's application to a health insurer to become a credentialed provider that includes:

(A) Information required by the health insurer;

(B) Proof that the provider is licensed by a health professional regulatory board as defined in ORS 676.160, the Long Term Care Administrators Board, the Board of Licensed Dietitians or the Behavior Analysis Regulatory Board;

(C) Proof of current registration with the Drug Enforcement Administration of the United States Department of Justice, if applicable to the provider's practice; and

(D) Proof that the provider is covered by a professional liability insurance policy or certification meeting the health insurer's requirements.

(b) "Credentialing period" means the period beginning on the date a health insurer receives a complete application and ending on the date the health insurer approves or rejects the complete application or 90 days after the health insurer receives the complete application, whichever is earlier.

(c) "Health insurer" means an insurer that offers managed health insurance or preferred provider organization insurance, other than a health maintenance organization as defined in ORS 750.005.

(d) "In-network" has the meaning given that term in ORS 743B.280.

(2) A health insurer shall approve or reject a complete application within 90 days of receiving the application.

(3)(a) A health insurer shall pay all claims for medical services covered by the health insurer that are provided by a provider during the credentialing period.

(b) A provider may submit claims for medical services provided during the credentialing period

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.

during or after the credentialing period.

(c) A health insurer may pay claims for medical services provided during the credentialing period:

(A) During or after the credentialing period.

(B) At the rate paid to nonparticipating providers.

(d) Notwithstanding paragraph (c) of this subsection, if the application is for a health care provider joining a provider group that is in-network with the health insurer, the health insurer shall pay all claims for medical services covered by the health insurer that are provided by the provider during the credentialing period at the same rate and according to the same payment schedule as in-network providers.

[*(d)*] **(e)** If a provider submits a claim for medical services provided during the credentialing period within six months after the end of the credentialing period, the health insurer may not deny payment of the claim on the basis of the health insurer's rules relating to timely claims submission.

(4) Subsection (3) of this section does not require a health insurer to pay claims for medical services provided during the credentialing period if:

(a) The provider was previously rejected or terminated as a participating provider in any health benefit plan underwritten or administered by the health insurer;

(b) The rejection or termination was due to the objectively verifiable failure of the provider to provide medical services within the recognized standards of the provider's profession; and

(c) The provider was given the opportunity to contest the rejection or termination before a panel of peers in a proceeding conducted in conformity with the Health Care Quality Improvement Act of 1986, 42 U.S.C. 11101 et seq.

SECTION 2. This 2025 Act takes effect on the 91st day after the date on which the 2025 regular session of the Eighty-third Legislative Assembly adjourns sine die.