# Senate Bill 1137

Sponsored by Senator BROADMAN; Senator REYNOLDS

**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 benefit plan to cover certain types of breast reconstruction services with certain rules. (Flesch Readability Score: 61.6).

Requires health benefit plans to cover autologous breast reconstruction procedures and related services with specific requirements related to out-of-pocket costs, utilization review, reimbursement rates and network adequacy.

**A BILL FOR AN ACT**

Relating to autologous breast reconstruction; 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 2025 Act is added to and made of part of the Insurance Code.**

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

**(a) "Accepted standard of care" means standards of care and clinical practice guidelines that are:**

**(A) Generally recognized by health care providers practicing in relevant clinical specialties; and**

**(B) Based on valid, evidence-based sources.**

**(b) "Autologous breast reconstruction procedure" includes but is not limited to:**

**(A) Superior gluteal artery perforator flap;**

**(B) Inferior gluteal artery perforator flap;**

**(C) Intercostal artery perforator flap;**

**(D) Lateral thigh perforator flap;**

**(E) Lumbar artery perforator flap;**

**(F) Muscle sparking transverse upper gracilis flap;**

**(G) Profunda artery perforator flap;**

**(H) Superficial inferior epigastric artery flap;**

**(I) Abdominal perforator exchange flap;**

**(J) Thoracodorsal artery perforator flap;**

**(K) Body lift perforator flap;**

**(L) Stacked hemiabdominal extended perforator flap;**

**(M) Deep inferior epigastric perforator artery;**

**(N) Hybrid procedures that involve both an autologous breast reconstruction procedure listed in this paragraph and breast implantations; and**

**(O) Any combination of the procedures listed in this paragraph.**

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

**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) "Out-of-network" has the meaning given that term in ORS 743B.280.**

**(e) "Revision to autologous breast reconstruction procedure" includes but is not limited to:**

**(A) Liposuction;**

**(B) Grafting;**

**(C) Nipple reconstruction;**

**(D) Nipple and areola tattoos;**

**(E) Fat necrosis excision;**

**(F) Capsulotomy; and**

**(G) Breast capsulorrhaphy.**

**(2) When prescribed in accordance with accepted standards of care by a licensed health care provider, a health benefit plan offered in this state that provides coverage of breast reconstruction services must provide coverage for autologous breast reconstruction procedures and all related medically necessary services, procedures and imaging including but not limited to revisions to autologous breast reconstruction procedures.**

**(3) A health benefit plan that provides coverage of autologous breast reconstruction procedures described in subsection (2) of this section, must provide coverage on a basis no less favorable than the coverage of other covered breast reconstruction services, including utilization review requirements.**

**(4) Coverage under this section may not be subject to terms and conditions, including out-of-pocket costs such as copayments, deductibles and coinsurance, other than the terms and conditions that apply to the reimbursement of the cost of the services and procedures described in subsection (2) provided by in-network providers.**

**(5)(a) A carrier offering a health benefit plan shall:**

**(A) Satisfy network adequacy standards as described in ORS 743B.505 relating to the coverage required in subsection (2) of this section; and**

**(B)(i) Contract with a network of providers that is sufficient in numbers and geographic locations to ensure that the services and procedures described in subsection (2) of this section are accessible to all enrollees without unreasonable delay; or**

**(ii) Ensure that all enrollees have geographic access without unreasonable delay to an out-of-network provider of the services and procedures described in subsection (2) of this section.**

**(b) As used in this subsection, "carrier" has the meaning given that term in ORS 743B.005.**

**(6) An out-of-network provider may not charge an enrollee for the cost of covered services and procedures described in subsection (2) of this section in an amount in excess of the reimbursement paid by the health benefit plan.**

**(7) A health benefit plan that reimburses out-of-network providers for the services and procedures specified in subsection (2) of this section must reimburse out-of-network providers at rates that are no less than the average amount of in-network reimbursement rates paid by the plan for comparable services and procedures.**

**(8) This section is exempt from ORS 743A.001.**

**SECTION 3.** ORS 743B.001, as amended by section 3, chapter 35, Oregon Laws 2024, 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, 743B.555 and 743B.602 and section 2, chapter 35, Oregon Laws 2024**, and section 2 of this 2025 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, a request for an exception to step therapy or a request for coverage of a treatment, drug, device or diagnostic or laboratory test that is subject to other utilization review requirements.

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

(3) "Clinical review criteria" means screening procedures, decision rules, medical protocols and clinical guidance used by an insurer or other entity in conducting utilization review and evaluating:

(a) Medical necessity;

(b) Appropriateness of an item or health service for which prior authorization is requested or for which an exception to step therapy has been requested as described in ORS 743B.602; or

(c) Any other coverage that is subject to utilization review.

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

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

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

(7) "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.

(8) "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.

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

(10) "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.

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

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

(13) "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.

(14) "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.

(15)(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.

(16) "Prior authorization" means a form of utilization review that requires a provider or an enrollee to request a determination by an insurer, 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.

(17)(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.

(18) "Step therapy" means a utilization review protocol, policy or program in which an insurer requires certain preferred drugs for treatment of a specific medical condition be proven ineffective or contraindicated before a prescribed drug may be reimbursed.

(19) "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. Section 2 of this 2025 Act applies to health benefit plans issued, renewed or extended on or after January 1, 2026.**