A-Engrossed
Senate Bill 507

Ordered by the Senate May 29
Including Senate Amendments dated May 29

Sponsored by Senators MONNES ANDERSON, KRUSE, Representatives SCHAUFLER, THOMPSON (at the request of Oregon Medical Association)

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.

Requires [*certain*] health insurers to approve or reject [*participating provider applications*] **provider's application to become credentialed provider** within [*30*] **90** days of receipt. Requires insurers [*that fail to approve or reject applications to reimburse providers for services provided after 30-day period*] **to pay claims for medical services provided by provider during credentialing period. Creates exception.**

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to preferred providers; creating new provisions; amending ORS 743.801; and declaring an emergency.

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

SECTION 1. Section 2 of this 2009 Act is added to and made a part of the Insurance Code.

SECTION 2. (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;

(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.

(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

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.

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 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) 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 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, 743.913 and 743A.012 **and section 2 of this 2009 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, 743.913, 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) "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) "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) "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, effi-

cacy or efficiency of health care services, procedures or settings.

SECTION 4. Section 2 of this 2009 Act applies to requests to enter into medical services contracts submitted by a provider on or after the effective date of this 2009 Act.

SECTION 5. This 2009 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2009 Act takes effect on its passage.