SENATE AMENDMENTS TO SENATE BILL 507

By COMMITTEE ON RULES

May 29

On page 1 of the printed bill, delete lines 6 through 22 and insert:

"**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 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.".