Updated Sponsors

House Bill 3607

Sponsored by Representative KENNEMER; Representatives BRUUN, HOYLE, TOMEI (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.**

Requires health insurers to report information to Director of Department of Consumer and Business Services regarding customary and usual fee paid for services of clinical social worker.

Requires House interim committee on health care to study reimbursement rates established by insurers for behavioral health care providers and interplay of such rates with mental health parity requirements.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to reimbursement rates for behavioral health care providers; creating new provisions; amending ORS 743.748; and declaring an emergency.

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

SECTION 1. ORS 743.748 is amended to read:

743.748. (1) Each carrier offering a health benefit plan shall submit to the Director of the Department of Consumer and Business Services on or before April 1 of each year a report that contains:

(a) The following information for the preceding year that is derived from the exhibit of premiums, enrollment and utilization included in the carrier's annual report:

(A) The total number of members;

(B) The total amount of premiums;

(C) The total amount of costs for claims;

(D) The medical loss ratio;

(E) The average amount of premiums per member per month; and

(F) The percentage change in the average premium per member per month, measured from the previous year.

(b) The following aggregate financial information for the preceding year that is derived from the carrier's annual report:

(A) The total amount of general administrative expenses, including identification of the five largest nonmedical administrative expenses and the assessment against the carrier for the Oregon Medical Insurance Pool;

(B) The total amount of the surplus maintained;

(C) The total amount of the reserves maintained for unpaid claims;

(D) The total net underwriting gain or loss; and

(E) The carrier's net income after taxes.

(c) The retention rate and claims experience of employer groups within the plan for the preceding year for association health plans as described in ORS 743.734 (7). This information is not

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.

subject to public disclosure under ORS chapter 192.

(d) An explanation of the methodology for calculating the insurer's payment or reimbursement for services in accordance with ORS 743A.024, including but not limited to the following with respect to the determination of the customary and usual fee of clinical social workers in an area:

(A) The methodology for determining the fee.

(B) Data used in the determination.

(C) The types of data used, such as service codes and modifiers, zip codes of the service delivery area, facility type and licensee type.

(D) The types of data collected by the insurer that are not used in the determination, including whether the insurer considers sliding fee rates charged by providers.

(E) How the insurer defines the area served by a clinical social worker.

(F) Any business or financial relationship between the insurer and a person that collects or modifies any of the data used in the determination.

(G) Other information prescribed by the director by rule.

(2) A carrier shall electronically submit the information described in subsection (1) of this section in a format and according to instructions prescribed by the Department of Consumer and Business Services by rule after obtaining a recommendation from the Health Insurance Reform Advisory Committee.

(3) The advisory committee shall evaluate the reporting requirements under subsection (1)(a) of this section by the following market segments:

(a) Individual health benefit plans;

(b) Health benefit plans for small employers;

(c) Health benefit plans for employers described in ORS 743.733;

(d) Health benefit plans for employers with more than 50 employees; and

(e) Association health plans described in ORS 743.734 (7).

(4) The department shall make the information reported under this section available to the public through a searchable public website on the Internet.

SECTION 2. ORS 743.748, as amended by section 10, chapter 752, Oregon Laws 2007, is amended to read:

743.748. (1) Each carrier offering a health benefit plan shall submit to the Director of the Department of Consumer and Business Services on or before April 1 of each year a report that contains:

(a) The following information for the preceding year that is derived from the exhibit of premiums, enrollment and utilization included in the carrier's annual report:

(A) The total number of members;

(B) The total amount of premiums;

(C) The total amount of costs for claims;

(D) The medical loss ratio;

(E) The average amount of premiums per member per month; and

(F) The percentage change in the average premium per member per month, measured from the previous year.

(b) The following aggregate financial information for the preceding year that is derived from the carrier's annual report:

(A) The total amount of general administrative expenses, including identification of the five

largest nonmedical administrative expenses and the assessment against the carrier for the Oregon Medical Insurance Pool;

(B) The total amount of the surplus maintained;

(C) The total amount of the reserves maintained for unpaid claims;

(D) The total net underwriting gain or loss; and

(E) The carrier's net income after taxes.

(c) An explanation of the methodology for calculating the insurer's payment or reimbursement for services in accordance with ORS 743A.024, including but not limited to the following with respect to the determination of the customary and usual fee of clinical social workers in an area:

(A) The methodology for determining the fee.

(B) Data used in the determination.

(C) The types of data used, such as service codes and modifiers, zip codes of the service delivery area, facility type and licensee type.

(D) The types of data collected by the insurer that are not used in the determination, including whether the insurer considers sliding fee rates charged by providers.

(E) How the insurer defines the area served by a clinical social worker.

(F) Any business or financial relationship between the insurer and a person that collects or modifies any of the data used in the determination.

(G) Other information prescribed by the director by rule.

(2) A carrier shall electronically submit the information described in subsection (1) of this section in a format and according to instructions prescribed by the Department of Consumer and Business Services by rule after obtaining a recommendation from the Health Insurance Reform Advisory Committee.

(3) The advisory committee shall evaluate the reporting requirements under subsection (1)(a) of this section by the following market segments:

(a) Individual health benefit plans;

(b) Health benefit plans for small employers;

(c) Health benefit plans for employers described in ORS 743.733; and

(d) Health benefit plans for employers with more than 50 employees.

(4) The department shall make the information reported under this section available to the public through a searchable public website on the Internet.

SECTION 3. The House interim committee on health care for the Seventy-fifth Legislative Assembly shall study the practices of insurers in determining customary and usual fees for behavioral health care providers. The committee shall:

(1) Examine how health insurers define customary and usual fees or rates in accordance with ORS 743A.024;

(2) Examine the issue of behavioral health care reimbursement rates within the context of mental health parity requirements under ORS 743A.168;

(3) Explore whether reductions in behavioral health care reimbursement rates undercut mental health parity requirements under ORS 743A.168; and

(4) Recommend administrative changes to the Director of the Department of Consumer and Business Services or presession file legislative measures.

SECTION 4. The amendments to ORS 743.748 by section 1 of this 2010 Act become operative January 1, 2011.

SECTION 5. This 2010 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2010 Act takes effect on its passage.