House Bill 2650

Sponsored by Representative DOHERTY (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 medical services contract to contain provision prohibiting health care provider from referring claim for reimbursement of health services to collection agency until provider has exhausted insurer's procedures for contesting denial, underpayment or refund of claim, notified patient of claim and given patient reasonable time to pay claim.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to payment of claims for the provision of health services; creating new provisions; amending ORS 743.803; and declaring an emergency.

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

SECTION 1. ORS 743.803 is amended to read:

743.803. (1) A medical services contract may not require the provider, as an element of the contract or as a condition of compensation for services, to agree:

(a) In the event of alleged improper medical treatment of a patient, to indemnify the other party to the medical services contract for any damages, awards or liabilities including but not limited to judgments, settlements, attorney fees, court costs and any associated charges incurred for any reason other than the negligence or intentional act of the provider or the provider's employees;

(b) To charge the other party to the medical services contract a rate for services rendered pursuant to the medical services contract that is no greater than the lowest rate that the provider charges for the same service to any other person;

(c) To deny care to a patient because of a determination made pursuant to the medical services contract that the care is not covered or is experimental, or to deny referral of a patient to another provider for the provision of such care, if the patient is informed that the patient will be responsible for the payment of such noncovered, experimental or referral care and the patient nonetheless desires to obtain such care or referral; or

(d) Upon the provider's withdrawal from or termination or nonrenewal of the medical services contract, not to treat or solicit a patient even at that patient's request and expense.

(2) A medical services contract shall:

(a) Grant to the provider adequate notice and hearing procedures, or such other procedures as are fair to the provider under the circumstances, prior to termination or nonrenewal of the medical services contract when such termination or nonrenewal is based upon issues relating to the quality of patient care rendered by the provider.

(b) Set forth generally the criteria used by the other party to the medical services contract for the termination or nonrenewal of the medical services contract.

(c) Entitle the provider to an annual accounting accurately summarizing the financial transactions between the parties to the medical services contract for that year.

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) Allow the provider to withdraw from the care of a patient when, in the professional judgment of the provider, it is in the best interest of the patient to do so.

(e) Provide that a doctor of medicine or osteopathy licensed under ORS chapter 677 shall be retained by the other party to the medical services contract and shall be responsible for all final medical and mental health decisions relating to coverage or payment made pursuant to the medical services contract.

(f) Provide that a physician who is practicing in conformity with ORS 677.095 may advocate a decision, policy or practice without being subject to termination or penalty for the sole reason of such advocacy.

(g)(A) Entitle the party to the medical services contract who is being reimbursed for the provision of health care services on a basis that includes financial risk withholds, or the party's representative, to a full accounting of health benefits claims data and related financial information on no less than a quarterly basis by the party to a medical service contract who has made reimbursement, as follows:

(i) The data shall include all pertinent information relating to the health care services provided, including related provider and patient information, reimbursements made and amounts withheld under the financial risk withhold provisions of the medical services contract for the period of time under reconciliation and settlement between the parties.

(ii) Any reconciliation and settlement undertaken pursuant to a medical services contract shall be based directly and exclusively upon data provided to the party who is being reimbursed for the provision of health care services.

(iii) All data, including supplemental information or documentation, necessary to finalize the reconciliation and settlement provisions of a medical services contract relating to financial risk withholds shall be provided to the party who is being reimbursed for the provision of health care services no later than 30 days prior to finalizing the reconciliation and settlement.

(B) Nothing in this paragraph shall be construed to prevent parties to a medical services contract from mutually agreeing to alternative reconciliation and settlement policies and procedures.

(h) Provide that when continuity of care is required to be provided under a health benefit plan by ORS 743.854, the insurer and the individual provider shall provide continuity of care to enrollees as provided in ORS 743.854.

(i) Provide that the provider will not assign to a collection agency the amount due the provider from the patient because the insurer denied or underpaid a claim or demanded a refund of a paid claim, until the provider has:

(A) Exhausted all of the insurer's procedures for contesting the denial, underpayment or refund of the claim under ORS 743.911, 743.912, 743.917 and 743.918; and

(B) Notified the patient of the claim and given the patient reasonable time to pay the claim.

(3) The other party to a medical services contract shall not:

(a) Refer to other documents or instruments in a contract unless the nonprovider party agrees to make available to the provider for review a copy of the documents or instruments within 72 hours of request; or

(b) Provide as an element of a contract with a third party relating to the provision of medical services to a patient of the provider that the provider's patient may not sue or otherwise recover from the nonprovider party, or must hold the nonprovider party harmless for, any and all expenses, damages, awards or liabilities that arise from the management decisions, utilization review pro-

visions or other policies or determinations of the nonprovider party that have an impact on the provider's treatment decisions and actions with regard to the patient.

(4) An insurer, independent practice association, medical or mental health clinic or other party to a medical services contract shall provide the criteria for selection of parties to future medical services contracts upon the request of current or prospective parties.

SECTION 2. The amendments to ORS 743.803 by section 1 of this 2013 Act apply to medical services contracts that are entered into, or renewed, on or after the effective date of this 2013 Act.

SECTION 3. This 2013 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2013 Act takes effect on its passage.