A-Engrossed

Senate Bill 560

Ordered by the Senate April 8
Including Senate Amendments dated April 8

Sponsored by Senators GELSER, KNOPP (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.

Requires insurer and health care service contractor to count payments made on behalf of enrollee for costs of care toward enrollee’s out-of-pocket maximum or cost-sharing.

A BILL FOR AN ACT

Relating to the cost of health care; creating new provisions; and amending ORS 743B.001 and 750.055.

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

SECTION 1. Section 2 of this 2021 Act is added to and made a part of the Insurance Code.

SECTION 2. (1) As used in this section:
   (a) “Cost-sharing” means coinsurance, copayments or deductibles.
   (b) “Enrollee” means an individual who is a beneficiary under a health plan.
   (c)(A) “Health plan” means:
   (i) An individual or group health benefit plan, as defined in ORS 743B.005;
   (ii) A plan providing coverage for a specific disease or condition only;
   (iii) A medical services contract; or
   (iv) Other similar certificate, policy, contract or arrangement or any endorsement or rider that covers all or a portion of the cost of an individual’s health care and that is subject to regulation by the Department of Consumer and Business Services.
   (B) “Health plan” does not include coverages provided by:
   (i) Medicare;
   (ii) The state medical assistance program;
   (iii) The federal government to federal employees;
   (iv) TRICARE;
   (v) Workers’ compensation;
   (vi) Limited benefit coverage; or
   (vii) Accident only, credit, disability or long term care insurance.
   (d) “Person” includes:
   (A) An individual;
   (B) A trust;
   (C) An estate;
   (D) A partnership;

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.

LC 2147
(E) A corporation;  
(F) An association;  
(G) A joint stock company;  
(H) An insurance company;  
(I) A state;  
(J) A political subdivision, instrumentality or municipal corporation of a state; or  
(K) A nonprofit organization.

(2) An insurer shall include all amounts paid by an enrollee or on behalf of an enrollee by another person when calculating the contribution of the enrollee to an out-of-pocket maximum or any other cost-sharing.

SECTION 3. ORS 750.055 is amended to read:

750.055. (1) The following provisions apply to health care service contractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:

(a) ORS 705.137, 705.138 and 705.139.

(b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.485, as provided in subsection (2) of this section, ORS 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.750, 731.752, 731.804, 731.808 and 731.844 to 731.992.


(d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680, and 733.695 to 733.780.

(e) ORS 734.014 to 734.440.

(f) ORS 742.001 to 742.009, 742.013, 742.016, 742.061, 742.065, 742.150 to 742.162 and 742.518 to 742.542.


(j) The following provisions of ORS chapter 744:

(A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance producers;  
(B) ORS 744.602 to 744.665, relating to the regulation of insurance consultants; and
(C) ORS 744.700 to 744.740, relating to the regulation of third party administrators.


(2) The following provisions of the Insurance Code apply to health care service contractors except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act:

(a) ORS 731.485, if the group practice health maintenance organization wholly owns and operates an in-house drug outlet.

(b) ORS 743A.024, unless the patient is referred by a physician, physician assistant or nurse practitioner associated with a group practice health maintenance organization.

(3) For the purposes of this section, health care service contractors are insurers.

(4) Any for-profit health care service contractor organized under the laws of any other state that is not governed by the insurance laws of the other state is subject to all requirements of ORS chapter 732.

(5)(a) A health care service contractor is a domestic insurance company for the purpose of determining whether the health care service contractor is a debtor, as defined in 11 U.S.C. 109.

(b) A health care service contractor's classification as a domestic insurance company under paragraph (a) of this subsection does not subject the health care service contractor to ORS 734.510 to 734.710.

(6) The Director of the Department of Consumer and Business Services may, after notice and hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025 and 750.045 that are necessary for the proper administration of these provisions.


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(a) ORS 705.137, 705.138 and 705.139.

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(f) ORS 742.001 to 742.009, 742.013, 742.016, 742.061, 742.065, 742.150 to 742.162 and 742.518 to 742.542.

(g) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.022, 743.023, 743.025,


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(4) Any for-profit health care service contractor organized under the laws of any other state that is not governed by the insurance laws of the other state is subject to all requirements of ORS chapter 732.

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(6) The Director of the Department of Consumer and Business Services may, after notice and hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025 and 750.045 that are necessary for the proper administration of these provisions.

SECTION 5. ORS 743B.001 is amended to read:

and 743B.555 and section 2, chapter 771, Oregon Laws 2013 and section 2 of this 2021 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.

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

(3) “Credit card” has the meaning given that term in 15 U.S.C. 1602.

(4) “Electronic funds transfer” has the meaning given that term in ORS 293.525.

(5) “Enrollee” has the meaning given that term in ORS 743B.005.

(6) “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.

(7) “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.

(8) “Health benefit plan” has the meaning given that term in ORS 743B.005.

(9) “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.

(10) “Insurer” includes a health care service contractor as defined in ORS 750.005.
(11) “Internal appeal” means a review by an insurer of an adverse benefit determination made by the insurer.

(12) “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.

(13) “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.

(14)(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.

(15) “Prior authorization” means a determination by an insurer upon request by a provider or an enrollee, 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.

(16)(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.

(17) “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 6. ORS 743B.001, as amended by section 12, chapter 284, Oregon Laws 2019, 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,
and 743B.555 and section 2 of this 2021 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.

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

(3) “Credit card” has the meaning given that term in 15 U.S.C. 1602.

(4) “Electronic funds transfer” has the meaning given that term in ORS 293.525.

(5) “Enrollee” has the meaning given that term in ORS 743B.005.

(6) “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.

(7) “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.

(8) “Health benefit plan” has the meaning given that term in ORS 743B.005.

(9) “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.
(10) “Insurer” includes a health care service contractor as defined in ORS 750.005.
(11) “Internal appeal” means a review by an insurer of an adverse benefit determination made
by the insurer.
(12) “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.
(13) “Medical services contract” means a contract between an insurer and an independent
practice association, between an insurer and a provider, between an independent practice associ-
ation 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 ser-
VICES. “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
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(A) Specifies a preferred network of providers managed, owned or under contract with or em-
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(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.
(15) “Prior authorization” means a determination by an insurer upon request by a provider or
an enrollee, 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.
(16)(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.
(17) “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 items, services, procedures or settings.

SECTION 7. Section 2 of this 2021 Act and the amendments to ORS 743B.001 and 750.055
by sections 3 to 6 of this 2021 Act apply to health plans, as defined in section 2 of this 2021
Act, issued, renewed or extended on or after the effective date of this 2021 Act.