

**A-Engrossed**  
**Senate Bill 560**

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

Sponsored by Senators GELSER, KNOPP (Pre-session 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**

1  
2 Relating to the cost of health care; creating new provisions; and amending ORS 743B.001 and  
3 750.055.

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

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

6 **SECTION 2. (1) As used in this section:**

7 (a) **"Cost-sharing" means coinsurance, copayments or deductibles.**

8 (b) **"Enrollee" means an individual who is a beneficiary under a health plan.**

9 (c)(A) **"Health plan" means:**

10 (i) **An individual or group health benefit plan, as defined in ORS 743B.005;**

11 (ii) **A plan providing coverage for a specific disease or condition only;**

12 (iii) **A medical services contract; or**

13 (iv) **Other similar certificate, policy, contract or arrangement or any endorsement or**  
14 **rider that covers all or a portion of the cost of an individual's health care and that is subject**  
15 **to regulation by the Department of Consumer and Business Services.**

16 (B) **"Health plan" does not include coverages provided by:**

17 (i) **Medicare;**

18 (ii) **The state medical assistance program;**

19 (iii) **The federal government to federal employees;**

20 (iv) **TRICARE;**

21 (v) **Workers' compensation;**

22 (vi) **Limited benefit coverage; or**

23 (vii) **Accident only, credit, disability or long term care insurance.**

24 (d) **"Person" includes:**

25 (A) **An individual;**

26 (B) **A trust;**

27 (C) **An estate;**

28 (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.

1 (E) A corporation;

2 (F) An association;

3 (G) A joint stock company;

4 (H) An insurance company;

5 (I) A state;

6 (J) A political subdivision, instrumentality or municipal corporation of a state; or

7 (K) A nonprofit organization.

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

11 **SECTION 3.** ORS 750.055 is amended to read:

12 750.055. (1) The following provisions apply to health care service contractors to the extent not  
13 inconsistent with the express provisions of ORS 750.005 to 750.095:

14 (a) ORS 705.137, 705.138 and 705.139.

15 (b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398  
16 to 731.430, 731.428, 731.450, 731.454, 731.485, as provided in subsection (2) of this section, ORS  
17 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.640 to 731.652,  
18 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.808 and 731.844 to 731.992.

19 (c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.596, not  
20 including ORS 732.582.

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

23 (e) ORS 734.014 to 734.440.

24 (f) ORS 742.001 to 742.009, 742.013, 742.016, 742.061, 742.065, 742.150 to 742.162 and 742.518 to  
25 742.542.

26 (g) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.022, 743.023, **743.025**,  
27 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.405, 743.406,  
28 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650  
29 to 743.656, 743.680 to 743.689, 743.788 and 743.790.

30 (h) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.034, 743A.036, 743A.040, 743A.044,  
31 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 743A.064, 743A.065, 743A.066,  
32 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105,  
33 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168, 743A.170,  
34 743A.175, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252 and 743A.260 and section 2,  
35 chapter 771, Oregon Laws 2013.

36 (i) ORS [743.025,] 743B.001, 743B.003 to 743B.127, 743B.128, 743B.130, 743B.195 to 743B.204,  
37 743B.220, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256,  
38 743B.257, 743B.258, 743B.280 to 743B.285, 743B.287, 743B.300, 743B.310, 743B.320, 743B.323, 743B.330,  
39 743B.340, 743B.341, 743B.342, 743B.343 to 743B.347, 743B.400, 743B.403, 743B.407, 743B.420, 743B.423,  
40 743B.450, 743B.451, 743B.452, 743B.453, 743B.470, 743B.475, 743B.505, 743B.550, 743B.555, 743B.601,  
41 743B.602 and 743B.800 **and section 2 of this 2021 Act.**

42 (j) The following provisions of ORS chapter 744:

43 (A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance produc-  
44 ers;

45 (B) ORS 744.602 to 744.665, relating to the regulation of insurance consultants; and

1 (C) ORS 744.700 to 744.740, relating to the regulation of third party administrators.

2 (k) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610,  
3 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

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

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

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

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

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

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

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

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

23 **SECTION 4.** ORS 750.055, as amended by section 21, chapter 771, Oregon Laws 2013, section  
24 7, chapter 25, Oregon Laws 2014, section 82, chapter 45, Oregon Laws 2014, section 9, chapter 59,  
25 Oregon Laws 2015, section 7, chapter 100, Oregon Laws 2015, section 7, chapter 224, Oregon Laws  
26 2015, section 11, chapter 362, Oregon Laws 2015, section 10, chapter 470, Oregon Laws 2015, section  
27 30, chapter 515, Oregon Laws 2015, section 10, chapter 206, Oregon Laws 2017, section 6, chapter  
28 417, Oregon Laws 2017, section 22, chapter 479, Oregon Laws 2017, section 10, chapter 7, Oregon  
29 Laws 2018, section 69, chapter 13, Oregon Laws 2019, section 38, chapter 151, Oregon Laws 2019,  
30 and section 5, chapter 441, Oregon Laws 2019, is amended to read:

31 750.055. (1) The following provisions apply to health care service contractors to the extent not  
32 inconsistent with the express provisions of ORS 750.005 to 750.095:

33 (a) ORS 705.137, 705.138 and 705.139.

34 (b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398  
35 to 731.430, 731.428, 731.450, 731.454, 731.485, as provided in subsection (2) of this section, ORS  
36 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.640 to 731.652,  
37 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.808 and 731.844 to 731.992.

38 (c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.596, not  
39 including ORS 732.582.

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

42 (e) ORS 734.014 to 734.440.

43 (f) ORS 742.001 to 742.009, 742.013, 742.016, 742.061, 742.065, 742.150 to 742.162 and 742.518 to  
44 742.542.

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

1 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.405, 743.406,  
2 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650  
3 to 743.656, 743.680 to 743.689, 743.788 and 743.790.

4 (h) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.034, 743A.036, 743A.040, 743A.044,  
5 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 743A.064, 743A.065, 743A.066,  
6 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105,  
7 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168, 743A.170,  
8 743A.175, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252 and 743A.260.

9 (i) ORS [743.025,] 743B.001, 743B.003 to 743B.127, 743B.128, 743B.130, 743B.195 to 743B.204,  
10 743B.220, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256,  
11 743B.257, 743B.258, 743B.280 to 743B.285, 743B.287, 743B.300, 743B.310, 743B.320, 743B.323, 743B.330,  
12 743B.340, 743B.341, 743B.342, 743B.343 to 743B.347, 743B.400, 743B.403, 743B.407, 743B.420, 743B.423,  
13 743B.450, 743B.451, 743B.452, 743B.453, 743B.470, 743B.475, 743B.505, 743B.550, 743B.555, 743B.601,  
14 743B.602 and 743B.800 **and section 2 of this 2021 Act.**

15 (j) The following provisions of ORS chapter 744:

16 (A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance produc-  
17 ers;

18 (B) ORS 744.602 to 744.665, relating to the regulation of insurance consultants; and

19 (C) ORS 744.700 to 744.740, relating to the regulation of third party administrators.

20 (k) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610,  
21 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

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

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

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

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

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

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

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

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

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

42 743B.001. As used in this section and ORS 743.008, 743.029, 743.035, 743A.190, 743B.195,  
43 743B.197, 743B.200, 743B.202, 743B.204, 743B.220, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253,  
44 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.310, 743B.400, 743B.403, 743B.405, 743B.420,  
45 743B.422, 743B.423, 743B.424, 743B.450, 743B.451, 743B.452, 743B.453, 743B.454, 743B.505, 743B.550

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

2 (1) "Adverse benefit determination" means an insurer's denial, reduction or termination of a  
3 health care item or service, or an insurer's failure or refusal to provide or to make a payment in  
4 whole or in part for a health care item or service, that is based on the insurer's:

5 (a) Denial of eligibility for or termination of enrollment in a health benefit plan;

6 (b) Rescission or cancellation of a policy or certificate;

7 (c) Imposition of a preexisting condition exclusion as defined in ORS 743B.005, source-of-injury  
8 exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or  
9 services;

10 (d) Determination that a health care item or service is experimental, investigational or not  
11 medically necessary, effective or appropriate;

12 (e) Determination that a course or plan of treatment that an enrollee is undergoing is an active  
13 course of treatment for purposes of continuity of care under ORS 743B.225; or

14 (f) Denial, in whole or in part, of a request for prior authorization.

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

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

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

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

20 (6) "Essential community provider" has the meaning given that term in rules adopted by the  
21 Department of Consumer and Business Services consistent with the description of the term in 42  
22 U.S.C. 18031 and the rules adopted by the United States Department of Health and Human Services,  
23 the United States Department of the Treasury or the United States Department of Labor to carry  
24 out 42 U.S.C. 18031.

25 (7) "Grievance" means:

26 (a) A communication from an enrollee or an authorized representative of an enrollee expressing  
27 dissatisfaction with an adverse benefit determination, without specifically declining any right to  
28 appeal or review, that is:

29 (A) In writing, for an internal appeal or an external review; or

30 (B) In writing or orally, for an expedited response described in ORS 743B.250 (2)(d) or an expe-  
31 dited external review; or

32 (b) A written complaint submitted by an enrollee or an authorized representative of an enrollee  
33 regarding the:

34 (A) Availability, delivery or quality of a health care service;

35 (B) Claims payment, handling or reimbursement for health care services and, unless the enrollee  
36 has not submitted a request for an internal appeal, the complaint is not disputing an adverse benefit  
37 determination; or

38 (C) Matters pertaining to the contractual relationship between an enrollee and an insurer.

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

40 (9) "Independent practice association" means a corporation wholly owned by providers, or whose  
41 membership consists entirely of providers, formed for the sole purpose of contracting with insurers  
42 for the provision of health care services to enrollees, or with employers for the provision of health  
43 care services to employees, or with a group, as described in ORS 731.098, to provide health care  
44 services to group members.

45 (10) "Insurer" includes a health care service contractor as defined in ORS 750.005.

1 (11) "Internal appeal" means a review by an insurer of an adverse benefit determination made  
2 by the insurer.

3 (12) "Managed health insurance" means any health benefit plan that:

4 (a) Requires an enrollee to use a specified network or networks of providers managed, owned,  
5 under contract with or employed by the insurer in order to receive benefits under the plan, except  
6 for emergency or other specified limited service; or

7 (b) In addition to the requirements of paragraph (a) of this subsection, offers a point-of-service  
8 provision that allows an enrollee to use providers outside of the specified network or networks at  
9 the option of the enrollee and receive a reduced level of benefits.

10 (13) "Medical services contract" means a contract between an insurer and an independent  
11 practice association, between an insurer and a provider, between an independent practice associ-  
12 ation and a provider or organization of providers, between medical or mental health clinics, and  
13 between a medical or mental health clinic and a provider to provide medical or mental health ser-  
14 vices. "Medical services contract" does not include a contract of employment or a contract creating  
15 legal entities and ownership thereof that are authorized under ORS chapter 58, 60 or 70, or other  
16 similar professional organizations permitted by statute.

17 (14)(a) "Preferred provider organization insurance" means any health benefit plan that:

18 (A) Specifies a preferred network of providers managed, owned or under contract with or em-  
19 ployed by an insurer;

20 (B) Does not require an enrollee to use the preferred network of providers in order to receive  
21 benefits under the plan; and

22 (C) Creates financial incentives for an enrollee to use the preferred network of providers by  
23 providing an increased level of benefits.

24 (b) "Preferred provider organization insurance" does not mean a health benefit plan that has  
25 as its sole financial incentive a hold harmless provision under which providers in the preferred  
26 network agree to accept as payment in full the maximum allowable amounts that are specified in  
27 the medical services contracts.

28 (15) "Prior authorization" means a determination by an insurer upon request by a provider or  
29 an enrollee, prior to the provision of health care that is subject to utilization review, that the  
30 insurer will provide reimbursement for the health care requested. "Prior authorization" does not  
31 include referral approval for evaluation and management services between providers.

32 (16)(a) "Provider" means a person licensed, certified or otherwise authorized or permitted by  
33 laws of this state to administer medical or mental health services in the ordinary course of business  
34 or practice of a profession.

35 (b) With respect to the statutes governing the billing for or payment of claims, "provider" also  
36 includes an employee or other designee of the provider who has the responsibility for billing claims  
37 for reimbursement or receiving payments on claims.

38 (17) "Utilization review" means a set of formal techniques used by an insurer or delegated by  
39 the insurer designed to monitor the use of or evaluate the medical necessity, appropriateness, effi-  
40 cacy or efficiency of health care items, services, procedures or settings.

41 **SECTION 6.** ORS 743B.001, as amended by section 12, chapter 284, Oregon Laws 2019, is  
42 amended to read:

43 743B.001. As used in this section and ORS 743.008, 743.029, 743.035, 743A.190, 743B.195,  
44 743B.197, 743B.200, 743B.202, 743B.204, 743B.220, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253,  
45 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.310, 743B.400, 743B.403, 743B.405, 743B.420,

1 743B.422, 743B.423, 743B.424, 743B.450, 743B.451, 743B.452, 743B.453, 743B.454, 743B.505, 743B.550  
2 and 743B.555 **and section 2 of this 2021 Act:**

3 (1) “Adverse benefit determination” means an insurer’s denial, reduction or termination of a  
4 health care item or service, or an insurer’s failure or refusal to provide or to make a payment in  
5 whole or in part for a health care item or service, that is based on the insurer’s:

6 (a) Denial of eligibility for or termination of enrollment in a health benefit plan;

7 (b) Rescission or cancellation of a policy or certificate;

8 (c) Imposition of a preexisting condition exclusion as defined in ORS 743B.005, source-of-injury  
9 exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or  
10 services;

11 (d) Determination that a health care item or service is experimental, investigational or not  
12 medically necessary, effective or appropriate;

13 (e) Determination that a course or plan of treatment that an enrollee is undergoing is an active  
14 course of treatment for purposes of continuity of care under ORS 743B.225; or

15 (f) Denial, in whole or in part, of a request for prior authorization.

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

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

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

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

21 (6) “Essential community provider” has the meaning given that term in rules adopted by the  
22 Department of Consumer and Business Services consistent with the description of the term in 42  
23 U.S.C. 18031 and the rules adopted by the United States Department of Health and Human Services,  
24 the United States Department of the Treasury or the United States Department of Labor to carry  
25 out 42 U.S.C. 18031.

26 (7) “Grievance” means:

27 (a) A communication from an enrollee or an authorized representative of an enrollee expressing  
28 dissatisfaction with an adverse benefit determination, without specifically declining any right to  
29 appeal or review, that is:

30 (A) In writing, for an internal appeal or an external review; or

31 (B) In writing or orally, for an expedited response described in ORS 743B.250 (2)(d) or an expe-  
32 dited external review; or

33 (b) A written complaint submitted by an enrollee or an authorized representative of an enrollee  
34 regarding the:

35 (A) Availability, delivery or quality of a health care service;

36 (B) Claims payment, handling or reimbursement for health care services and, unless the enrollee  
37 has not submitted a request for an internal appeal, the complaint is not disputing an adverse benefit  
38 determination; or

39 (C) Matters pertaining to the contractual relationship between an enrollee and an insurer.

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

41 (9) “Independent practice association” means a corporation wholly owned by providers, or whose  
42 membership consists entirely of providers, formed for the sole purpose of contracting with insurers  
43 for the provision of health care services to enrollees, or with employers for the provision of health  
44 care services to employees, or with a group, as described in ORS 731.098, to provide health care  
45 services to group members.

1 (10) “Insurer” includes a health care service contractor as defined in ORS 750.005.

2 (11) “Internal appeal” means a review by an insurer of an adverse benefit determination made  
3 by the insurer.

4 (12) “Managed health insurance” means any health benefit plan that:

5 (a) Requires an enrollee to use a specified network or networks of providers managed, owned,  
6 under contract with or employed by the insurer in order to receive benefits under the plan, except  
7 for emergency or other specified limited service; or

8 (b) In addition to the requirements of paragraph (a) of this subsection, offers a point-of-service  
9 provision that allows an enrollee to use providers outside of the specified network or networks at  
10 the option of the enrollee and receive a reduced level of benefits.

11 (13) “Medical services contract” means a contract between an insurer and an independent  
12 practice association, between an insurer and a provider, between an independent practice associ-  
13 ation and a provider or organization of providers, between medical or mental health clinics, and  
14 between a medical or mental health clinic and a provider to provide medical or mental health ser-  
15 vices. “Medical services contract” does not include a contract of employment or a contract creating  
16 legal entities and ownership thereof that are authorized under ORS chapter 58, 60 or 70, or other  
17 similar professional organizations permitted by statute.

18 (14)(a) “Preferred provider organization insurance” means any health benefit plan that:

19 (A) Specifies a preferred network of providers managed, owned or under contract with or em-  
20 ployed by an insurer;

21 (B) Does not require an enrollee to use the preferred network of providers in order to receive  
22 benefits under the plan; and

23 (C) Creates financial incentives for an enrollee to use the preferred network of providers by  
24 providing an increased level of benefits.

25 (b) “Preferred provider organization insurance” does not mean a health benefit plan that has  
26 as its sole financial incentive a hold harmless provision under which providers in the preferred  
27 network agree to accept as payment in full the maximum allowable amounts that are specified in  
28 the medical services contracts.

29 (15) “Prior authorization” means a determination by an insurer upon request by a provider or  
30 an enrollee, prior to the provision of health care that is subject to utilization review, that the  
31 insurer will provide reimbursement for the health care requested. “Prior authorization” does not  
32 include referral approval for evaluation and management services between providers.

33 (16)(a) “Provider” means a person licensed, certified or otherwise authorized or permitted by  
34 laws of this state to administer medical or mental health services in the ordinary course of business  
35 or practice of a profession.

36 (b) With respect to the statutes governing the billing for or payment of claims, “provider” also  
37 includes an employee or other designee of the provider who has the responsibility for billing claims  
38 for reimbursement or receiving payments on claims.

39 (17) “Utilization review” means a set of formal techniques used by an insurer or delegated by  
40 the insurer designed to monitor the use of or evaluate the medical necessity, appropriateness, effi-  
41 cacy or efficiency of health care items, services, procedures or settings.

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