

# Enrolled House Bill 3008

Sponsored by Representatives PHAM H, JAVADI, BYNUM; Representative DEXTER (at the request of Oregon Dental Association) (Pre-session filed.)

CHAPTER .....

AN ACT

Relating to health insurance; creating new provisions; and amending section 6, chapter 37, Oregon Laws 2022.

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

**SECTION 1.** Sections 2 and 3 of this 2023 Act are added to and made a part of the Insurance Code.

**SECTION 2.** (1) As used in this section, “dental insurer” means an insurer that offers a policy or certificate of insurance or other contract, that provides only a dental benefit.

(2) A dental insurer may pay a claim for reimbursement made by a dental care provider using a credit card or electronic funds transfer payment method that imposes on the provider a fee or similar charge to process the payment if:

(a) The dental insurer notifies the provider, in advance, of the potential fees or other charges associated with the use of the credit card or electronic funds transfer payment method;

(b) The dental insurer offers the provider an alternative payment method that does not impose fees or similar charges on the provider; and

(c) The provider or a designee of the provider elects to accept a payment of the claim using the credit card or electronic funds transfer payment method.

(3) If a dental insurer contracts with a vendor to process payments of dental providers’ claims, the dental insurer shall require the vendor to comply with the provisions of subsection (2)(a) of this section.

**SECTION 3.** (1) As used in this section:

(a) “Dental insurer” means an insurer that offers a policy or certificate of insurance or other contract, that provides only a dental benefit.

(b)(A) “Material modification” includes, but is not limited to, changes to the terms or conditions of a contract that alter:

(i) Reimbursement rates paid to dental care providers;

(ii) Fee schedules for dental care providers; or

(iii) Dental benefits or covered procedures under a plan for which a dental care provider is a network provider.

(B) “Material modification” does not include adding a new third party to an existing third party network contract without any material modification to the third party network contract.

(c) "Provider network contract" means a contract entered into between a dental care provider and a dental insurer for the provision of services to enrollees in plans offered by the dental insurer.

(d) "Third party" means an entity that enters into a third party network contract with a dental insurer.

(e) "Third party network contract" means a contract entered into between a dental insurer and third party insurer to gain access to the dental care services and discounted rates of a dental care provider under the dental insurer's provider network contract with the dental care provider.

(2) A dental insurer may enter into a third party network contract to provide access to the dental care services and discounted rates of a dental care provider under a provider network contract only if:

(a) The dental care provider in the network chooses to allow the third party to access the dental care provider's services and discounted rates:

(A) At the time the contract is entered into or renewed; and

(B) Whenever there is a material modification to the third party network contract;

(b) The dental insurer allows the dental care provider to contract directly with the third party instead of allowing the third party to access the dental care provider's services and discounted rates; and

(c) The third party network contract obligates the third party to comply with all applicable terms, limitations and conditions of the provider network contract.

(3) A dental insurer may not cancel or otherwise terminate a network provider contract with a dental care provider on the grounds that the dental care provider refuses to allow access by a third party to the dental care services and discounted rates of the dental care provider.

(4) A dental insurer that contracts with a third party to provide access to the services and discounted rates of a dental care provider under a provider network contract shall:

(a) At the time a provider network contract is entered into, renewed or extended, give to the provider, in writing or electronically, a list of all third parties known by the dental insurer to which the dental insurer has or will provide access to the dental care services and discounted rates of the provider under the provider network contract;

(b) Maintain an Internet website through which the provider may obtain a list, updated at least every 90 days, of all third parties that have access to the provider's dental care services and discounted rates under the provider network contract;

(c) Require a third party to identify on each remittance or explanation of payment sent to a provider the source of any contractual discount in rates taken by the third party under the provider network contract;

(d) Notify the provider no less than 30 days prior to the effective date of a new third party network contract;

(e) Notify each third party described under paragraph (a) or (b) of this subsection of the termination of the provider network contract no later than 30 days prior to the effective date of the termination; and

(f) Make available to a provider within 30 days of the provider's request a copy of the provider network contract currently in force that was relied upon by the dental insurer in the adjudication of the provider's claim.

(5) The notice required under subsection (4)(d) and (e) of this section can be provided by any reasonable means, including but not limited to written notice, electronic communication or an update to an electronic database.

(6) Subject to any applicable continuity of care requirements, agreements or contractual provisions, a third party's right to access a dental care provider's services and discounted rates under a provider network contract shall terminate on the date the provider network contract is terminated.

(7) **The requirements of this section may not be waived by agreement. Any contract provision that purports to waive the requirements of this section or that conflicts with the requirements of this section is null and void.**

**(8) This section does not apply to:**

**(a) Contracts between a dental insurer and a licensee or affiliate of the dental insurer.**

**(b) The state medical assistance program.**

**(c) A dental insurer that relies only on employees of the insurer to provide dental care.**

**SECTION 4. Sections 2 and 3 of this 2023 Act apply to contracts entered into, renewed or extended on or after the effective date of this 2023 Act.**

**SECTION 5.** Section 6, chapter 37, Oregon Laws 2022, is amended to read:

**Sec. 6.** (1) As used in this section, “primary care” means outpatient behavioral health services, nonspecialty medical services or the coordination of health care for the purpose of:

(a) Promoting or maintaining behavioral and physical health and wellness; and

(b) Diagnosis, treatment or management of acute or chronic conditions caused by disease, injury or illness.

(2) An individual or group policy or certificate of health insurance that is not offered on the health insurance exchange and that reimburses the cost of hospital, medical or surgical expenses, other than coverage limited to expenses from accidents or specific diseases and limited benefit coverage, shall, in each plan year, reimburse the cost of at least three primary care visits for behavioral health or physical health treatment.

(3) The coverage under subsection (2) of this section:

(a) May not be subject to copayments, coinsurance or deductibles, except as provided in ORS 742.008 **and subsection (5) of this section;** and

(b) Is in addition to one annual preventive primary care visit that must be covered without cost-sharing.

(4) An insurer that offers a qualified health plan on the health insurance exchange must offer at least one plan in each metal tier offered by the insurer that provides the coverage described in subsections (2) and (3) of this section.

**(5) The Department of Consumer and Business Services may adopt rules to allow an individual or group policy or certificate of health insurance to impose a copayment of not more than \$5 for a primary care visit if necessary to comply with the requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110-343).**

[(5)] (6) This section does not apply to health benefit plans offered to public employees by insurers that contract with the Public Employees’ Benefit Board or the Oregon Educators Benefit Board.

[(6)] (7) This section is exempt from ORS 743A.001.

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**Passed by House March 28, 2023**

**Repassed by House June 23, 2023**

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Timothy G. Sekerak, Chief Clerk of House

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Dan Rayfield, Speaker of House

**Passed by Senate June 21, 2023**

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Rob Wagner, President of Senate

**Received by Governor:**

.....M.,....., 2023

**Approved:**

.....M.,....., 2023

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Tina Kotek, Governor

**Filed in Office of Secretary of State:**

.....M.,....., 2023

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Secretary of State