

House Bill 3607

Sponsored by Representative KENNEMER (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

1
2 Relating to reimbursement rates for behavioral health care providers; creating new provisions;
3 amending ORS 743.748; and declaring an emergency.

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

5 **SECTION 1.** ORS 743.748 is amended to read:

6 743.748. (1) Each carrier offering a health benefit plan shall submit to the Director of the De-
7 partment of Consumer and Business Services on or before April 1 of each year a report that con-
8 tains:

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

11 (A) The total number of members;

12 (B) The total amount of premiums;

13 (C) The total amount of costs for claims;

14 (D) The medical loss ratio;

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

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

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

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

23 (B) The total amount of the surplus maintained;

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

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

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

27 (c) The retention rate and claims experience of employer groups within the plan for the pre-
28 ceding year for association health plans as described in ORS 743.734 (7). This information is not
29 subject to public disclosure under ORS chapter 192.

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

5 (A) The methodology for determining the fee.

6 (B) Data used in the determination.

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

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

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

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

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

15 (2) A carrier shall electronically submit the information described in subsection (1) of this sec-
 16 tion in a format and according to instructions prescribed by the Department of Consumer and
 17 Business Services by rule after obtaining a recommendation from the Health Insurance Reform Ad-
 18 visory Committee.

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

21 (a) Individual health benefit plans;

22 (b) Health benefit plans for small employers;

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

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

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

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

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

30 743.748. (1) Each carrier offering a health benefit plan shall submit to the Director of the De-
 31 partment of Consumer and Business Services on or before April 1 of each year a report that con-
 32 tains:

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

35 (A) The total number of members;

36 (B) The total amount of premiums;

37 (C) The total amount of costs for claims;

38 (D) The medical loss ratio;

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

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

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

44 (A) The total amount of general administrative expenses, including identification of the five
 45 largest nonmedical administrative expenses and the assessment against the carrier for the Oregon

1 Medical Insurance Pool;

2 (B) The total amount of the surplus maintained;

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

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

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

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

10 (A) **The methodology for determining the fee.**

11 (B) **Data used in the determination.**

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

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

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

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

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

20 (2) A carrier shall electronically submit the information described in subsection (1) of this sec-
21 tion in a format and according to instructions prescribed by the Department of Consumer and
22 Business Services by rule after obtaining a recommendation from the Health Insurance Reform Ad-
23 visory Committee.

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

26 (a) Individual health benefit plans;

27 (b) Health benefit plans for small employers;

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

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

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

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

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

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

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

41 (4) **Recommend administrative changes to the Director of the Department of Consumer**
42 **and Business Services or pre-session file legislative measures.**

43 **SECTION 4. The amendments to ORS 743.748 by section 1 of this 2010 Act become oper-**
44 **ative January 1, 2011.**

45 **SECTION 5. This 2010 Act being necessary for the immediate preservation of the public**

1 **peace, health and safety, an emergency is declared to exist, and this 2010 Act takes effect**
2 **on its passage.**

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