Senate Bill 231

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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.**

Prohibits insurer from seeking refund of payment on claim submitted by health care provider after date specified by agreement but no more than 24 months after claim was paid. Extends time for provider to seek additional payment if there is more than one insurer providing coverage, under specified conditions. Applies to contracts between providers and insurers in effect on or after January 1, 2012.

A BILL FOR AN ACT

Relating to health insurance claims by providers; creating new provisions; and amending ORS 743.912 and 743.917.

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

SECTION 1. ORS 743.912 is amended to read:

743.912. (1) As used in this section, "refund" means the return, either directly or through an offset to a future claim, of some or all of a payment already received by a health care provider.

(2) Except in the case of fraud or abuse of billing, and except as provided in subsections (3) and (5) of this section, a health insurer may not:

(a) Request from a health care provider a refund of a payment previously made to satisfy a claim unless the health insurer:

(A) Requests the refund in writing within **the earlier of a period specified by contract with the provider or** 24 months after the date the payment was made; and

(B) Specifies in the written request why the health insurer believes the provider owes the refund.

(b) Request that a contested refund be paid earlier than six months after the health care provider receives the request.

(3) A health insurer may not do the following for reasons related to coordination of benefits with another health insurer or entity responsible for payment of a claim:

(a) Request from a health care provider a refund of a payment previously made to satisfy a claim unless the health insurer:

(A) Requests the refund in writing within 30 months after the date the payment was made;

(B) Specifies in the written request why the health insurer believes the provider owes the refund; and

(C) Includes in the written request the name and mailing address of the other health insurer or entity that has primary responsibility for payment of the claim.

(b) Request that a contested refund be paid earlier than six months after the provider receives the request.

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.

(4) If a health care provider fails to contest a refund request in writing to the health insurer within 30 days after receiving the request, the request is deemed accepted and the provider must pay the refund within 30 days after the request is deemed accepted. If the provider has not paid the refund within 30 days after the request is deemed accepted, the health insurer may recover the amount through an offset to a future claim.

(5) A health insurer may at any time request from a health care provider a refund of a payment previously made to satisfy a claim if:

(a) A third party, including a government entity, is found responsible for satisfaction of the claim as a consequence of liability imposed by law; and

(b) The health insurer is unable to recover directly from the third party because the third party has already paid or will pay the provider for the health care services covered by the claim.

(6) If a contract between a health insurer and a health care provider conflicts with this section, the provisions of this section prevail. However, nothing in this section prohibits a health care provider from choosing at any time to refund to a health insurer any payment previously made to satisfy a claim.

(7) This section neither permits nor precludes a health insurer from recovering from a subscriber, enrollee or beneficiary any amounts paid to a health care provider for benefits to which the subscriber, enrollee or beneficiary was not entitled under the terms and conditions of the health plan, insurance policy or other benefit agreement.

(8) This section does not apply to claims for health care services provided through dental-only health insurers, through Medicare or through Medicare supplemental plans.

SECTION 2. ORS 743.917 is amended to read:

743.917. (1)**(a)** Except in the case of fraud and except as provided in subsection (2) of this section, a health care provider may not:

[*(a)*] **(A)** Request additional payment from a health insurer to satisfy a claim unless the provider:

[*(A)*] **(i)** Requests the additional payment in writing within 24 months after the date the claim was denied or payment intended to satisfy the claim was made; and

[*(B)*] **(ii)** Specifies in the written request why the provider believes the health insurer owes the additional payment.

[*(b)*] **(B)** Request that an additional payment be paid earlier than six months after the health insurer receives the request.

(b) A request for additional payment shall be considered timely under this subsection if a provider made a timely request for additional payment, that request was denied after the 24-month period and the provider subsequently filed a new request for additional payment with a different insurer within 24 months after the denial of the claim by the previous insurer.

(2) A health care provider may not do the following for reasons related to coordination of benefits with another health insurer or entity responsible for payment of a claim:

(a) Request additional payment from a health insurer to satisfy a claim unless the provider:

(A) Requests the additional payment in writing within 30 months after the date the claim was denied or payment intended to satisfy the claim was made;

(B) Specifies in the written request why the provider believes the health insurer owes the additional payment; and

(C) Includes in the written request the name and mailing address of the other health insurer or entity that has disclaimed responsibility for payment of the claim.

(b) Request that the additional payment be paid earlier than six months after the health insurer receives the request.

(3) If a contract between a health insurer and a health care provider conflicts with this section, the provisions of this section prevail. However, nothing in this section prohibits a health insurer from choosing at any time to make additional payments to a health care provider to satisfy a claim.

(4) This section does not apply to claims for health care services provided through dental-only health insurers, through Medicare or through Medicare supplemental plans.

SECTION 3. The amendments to ORS 743.912 and 743.917 by sections 1 and 2 of this 2011 Act apply to contracts between health insurers and health care providers that are in effect on or after the effective date of this 2011 Act.