

REVENUE: No revenue impact

FISCAL: No fiscal impact

Action: Do Pass with Amendments to the A-Engrossed Measure. (Printed B-Engrossed)

Vote: 5 - 0 - 1

Yeas: Edwards, Monroe, Starr, Thomsen, Beyer

Nays: 0

Exc.: Girod

Prepared By: Patrick Brennan, Administrator

Meeting Dates: 2/25

WHAT THE MEASURE DOES: Deletes limiting interim medical benefits to certain types of services. Requires health benefit plan to expedite pre-authorizations and guarantee payment of expenses for medical services provided prior to the acceptance or denial of the claim according to the terms, conditions and benefits of the plan. Deletes requirement that workers' compensation insurer or self-insured employer pay any balance after the health benefit plan makes payment. Requires, if claim is accepted, the workers' compensation insurer or self-insured employer to pay for medical services provided, including reimbursement to the injured worker or health benefit plan, subject to terms and conditions of workers' compensation statutes. Deletes provision allowing workers' compensation insurer or self-employed insurer to recover expenses for interim medical benefits on denied claims. Requires, if claim is denied, health benefit plan to pay for medical services provided according to the terms, conditions and benefits of the plan. Specifies, in the state insurance code, that a health benefit plan may not exclude, and shall expedite pre-authorizations required for, work-related injuries or occupational diseases when the worker is waiting for a workers' compensation claim to be accepted or denied. Requires a health benefit plan to guarantee payment of pre-authorized medical services according to the terms, conditions and benefits of the plan if the claim is found not to be a compensable workers' compensation claim.

ISSUES DISCUSSED:

- Product of extensive discussion with stakeholders
- Some medical bills paid by health insurance are eligible to be paid by Workers' Compensation benefits
- Unanimous support from Workers' Compensation Management-Labor Advisory Committee
- Effect of committee amendment
- Applies to public employers and private employers

EFFECT OF COMMITTEE AMENDMENT: Deletes portions of ORS 656.247(4)(a). Deletes ORS 656.247(5). Specifies that section 2 applies to health benefit plans entered into or renewed on or after the effective date of the measure.

BACKGROUND: A workers' compensation claim must be accepted or denied within 60 days after the employer has notice or knowledge of the claim. During the time it takes to make the determination, the worker is eligible to receive the following interim medical benefits: diagnostics, pain alleviation, and services to stabilize the worker's condition and prevent further disability. Currently, the interim medical benefits are paid as follows:

- If the claim is accepted, the workers' compensation insurer or self-insured employer pays for the medical services subject to the limitations and conditions of the workers' compensation statutes.
- If the claim is denied, the workers' health benefit plan is the first payer of the expenses according to the terms, conditions and benefits of the plan, and the workers' compensation insurer or self-insured employer pays any balance remaining for services subject to the limitations and conditions of the workers' compensation statutes.
- However, if a claim is denied within 14 days, the workers' compensation insurer or self-insured employer does not make any payments.

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This summary has not been adopted or officially endorsed by action of the committee.

Prior to 2001, there was no guarantee the medical provider would be paid for services provided before acceptance or denial of the claim. Without guaranteed payment, medical providers were reluctant to provide services. Passage of Senate Bill 485 in 2001 was intended to provide assurance of full payment to the medical provider. The worker could receive medical treatment while responsibility for making payment would be determined after the claim was either denied or accepted. Currently, some injured workers believe they do not receive treatment in a timely manner or that treatment limited during the interim period is not adequate. Some workers want to receive treatment to restore their condition, as opposed to just stabilizing their condition, but such treatment can fall outside of the payable interim medical benefits.