HOUSE AMENDMENTS TO HOUSE BILL 2468

By COMMITTEE ON HEALTH CARE

March 27

On page 1 of the printed bill, line 2, after "743.804," insert "746.230,".

In line 5, delete "Sections 2 and 3" and insert "Section 2" and delete "are" and insert "is".

In line 8, after "erage" insert "to individuals or to small employers, as defined in ORS 743.730,".

In line 10, after "services" insert "under the health benefit plan".

In line 28, after "ensure" delete the rest of the line and delete line 29 and insert "access to care by enrollees who reside in locations within the health benefit plan's service area that are designated by the Health Resources and Services Administration of the United States Department of Health and Human Services as health professional shortage areas or low-income zip codes.".

On page 2, line 11, after "shall" delete the rest of the line and insert "be consistent with the provisions of 42 U.S.C.".

Delete lines 15 and 16.

In line 17, delete "(4)" and insert "(3)" and after "shall" delete the rest of the line and insert "use one of the following methods in".

In line 18, delete "for".

In line 19, delete "using".

Delete lines 20 through 30 and insert:

"(a) An approach by which an insurer submits evidence that the insurer is complying with at least one of the factors prescribed by the department by rule from each of the following categories:

"(A) Access to care consistent with the needs of the enrollees served by the network;

"(B) Consumer satisfaction;

"(C) Transparency; and

"(D) Quality of care and cost containment; or

"(b) A nationally recognized standard adopted by the department and adjusted, as necessary, to reflect the age demographics of the enrollees in the plan.".

In line 31, delete "(5)" and insert "(4)".

Delete lines 34 through 43 and insert:

"(5) This section does not require an insurer to submit provider contracts to the department for review.".

In line 44, delete "4" and insert "3".

On page 3, line 3, delete "sections 2 and 3" and insert "section 2".

Delete lines 19 and 20 and insert:

"(4) 'Essential community provider' has the meaning given that term in rules adopted by the Department of Consumer and Business Services consistent with the description of the term in 42 U.S.C. 18031 and the rules adopted by the United States Department of Health and Human Services,

the United States Department of the Treasury or the United States Department of Labor to carry out 42 U.S.C. 18031.".

On page 4, line 33, delete "5" and insert "4".

In line 38, delete "sections 2 and 3" and insert "section 2".

On page 5, delete lines 9 and 10 and insert:

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

On page 6, line 23, delete "6" and insert "5".

On page 9, after line 7, insert:

"**SECTION 6.** ORS 746.230, as amended by section 79, chapter 45, Oregon Laws 2014, is amended to read:

"746.230. (1) No insurer or other person shall commit or perform any of the following unfair claim settlement practices:

"(a) Misrepresenting facts or policy provisions in settling claims;

"(b) Failing to acknowledge and act promptly upon communications relating to claims;

"(c) Failing to adopt and implement reasonable standards for the prompt investigation of claims;

"(d) Refusing to pay claims without conducting a reasonable investigation based on all available information;

"(e) Failing to affirm or deny coverage of claims within a reasonable time after completed proof of loss statements have been submitted;

"(f) Not attempting, in good faith, to promptly and equitably settle claims in which liability has become reasonably clear;

"(g) Compelling claimants to initiate litigation to recover amounts due by offering substantially less than amounts ultimately recovered in actions brought by such claimants;

"(h) Attempting to settle claims for less than the amount to which a reasonable person would believe a reasonable person was entitled after referring to written or printed advertising material accompanying or made part of an application;

"(i) Attempting to settle claims on the basis of an application altered without notice to or consent of the applicant;

"(j) Failing, after payment of a claim, to inform insureds or beneficiaries, upon request by them, of the coverage under which payment has been made;

"(k) Delaying investigation or payment of claims by requiring a claimant or the claimant's physician, physician assistant or nurse practitioner to submit a preliminary claim report and then requiring subsequent submission of loss forms when both require essentially the same information;

"(L) Failing to promptly settle claims under one coverage of a policy where liability has become reasonably clear in order to influence settlements under other coverages of the policy; or

"(m) Failing to promptly provide the proper explanation of the basis relied on in the insurance policy in relation to the facts or applicable law for the denial of a claim.

"(2) No insurer shall refuse, without just cause, to pay or settle claims arising under coverages provided by its policies with such frequency as to indicate a general business practice in this state, which general business practice is evidenced by:

"(a) A substantial increase in the number of complaints against the insurer received by the

Department of Consumer and Business Services;

"(b) A substantial increase in the number of lawsuits filed against the insurer or its insureds by claimants; or

"(c) Other relevant evidence.

"[*(3)(a) No health maintenance organization, as defined in ORS 750.005, shall unreasonably withhold the granting of participating provider status from a class of statutorily authorized health care providers for services rendered within the lawful scope of practice if the health care providers are licensed as such and reimbursement is for services mandated by statute.*]

"[*(b) Any health maintenance organization that fails to comply with paragraph (a) of this subsection shall be subject to discipline under ORS 746.015.*]

"[*(c) This subsection does not apply to group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Health Maintenance Organization Act.*]".

In line 31, delete "sections 2 and 3" and insert "section 2".

On page 10, line 31, delete "sections 2 and 3" and insert "section 2".

On page 11, line 30, delete "sections 2 and 3" and insert "section 2".

On page 12, line 23, delete "sections 2 and 3" and insert "section 2".

In line 41, delete "Sections 2 and 3" and insert "Section 2".

In line 42, after "743.804," insert "746.230," and delete "4" and insert "3".

In line 44, delete "Sections 2 and 3" and insert "Section 2" and after "743.804," insert "746.230,".

In line 45, delete "4" and insert "3".

On page 13, line 4, delete "sections 2 and 3" and insert "section 2".

In line 5, after "743.804," insert "746.230," and delete "4" and insert "3".