HB 3021-1
(LC 2237)
3/4/15 (LHF/ps)

PROPOSED AMENDMENTS TO
HOUSE BILL 3021

In line 2 of the printed bill, after "claims" insert "; amending ORS 743.801, 743.804 and 743.911".

Delete lines 4 through 14 and insert:

"SECTION 1. ORS 743.911 is amended to read:

"743.911. (1) Except as provided in this subsection, when a claim under a health benefit plan is submitted to an insurer by a provider on behalf of an enrollee, the insurer shall pay a clean claim or deny the claim not later than 30 days after the date on which the insurer receives the claim. If an insurer requires additional information before payment of a claim, not later than 30 days after the date on which the insurer receives the claim, the insurer shall notify the enrollee and the provider in writing and give the enrollee and the provider an explanation of the additional information needed to process the claim. The insurer shall pay a clean claim or deny the claim not later than 30 days after the date on which the insurer receives the additional information.

"(2) A contract between an insurer and a provider may not include a provision governing payment of claims that limits the rights and remedies available to a provider under this section and ORS 743.913 or has the effect of relieving either party of their obligations under this section and ORS 743.913.

"**(3) An insurer may pay a claim 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 insurer notifies the provider, in advance, of the fee or other charges associated with the use of the credit card or electronic funds transfer payment method;

"(b) The 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 payment method.

"[*(3)*] **(4)** An insurer shall establish a method of communicating to providers the procedures and information necessary to complete claim forms. The procedures and information must be reasonably accessible to providers.

"[*(4)*] **(5)** This section does not create an assignment of payment to a provider.

"[*(5)*] **(6)** Each insurer shall report to the Director of the Department of Consumer and Business Services annually on its compliance under this section according to requirements established by the director.

"[*(6)*] **(7)** The director shall adopt by rule a definition of 'clean claim' and shall consider the definition of 'clean claim' used by the federal Department of Health and Human Services for the payment of Medicare claims.

"SECTION 2. ORS 743.801 is amended to read:

"743.801. As used in this section and ORS 743.803, 743.804, 743.806, 743.807, 743.808, 743.811, 743.814, 743.817, 743.819, 743.821, 743.823, 743.827, 743.829, 743.831, 743.834, 743.837, 743.839, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.894, 743.911, 743.912, 743.913, 743.917 and 743.918:

"(1) 'Adverse benefit determination' means an insurer's denial, reduction or termination of a health care item or service, or an insurer's failure or refusal to provide or to make a payment in whole or in part for a health care item or service, that is based on the insurer's:

"(a) Denial of eligibility for or termination of enrollment in a health

benefit plan;

"(b) Rescission or cancellation of a policy or certificate;

"(c) Imposition of a preexisting condition exclusion as defined in ORS 743.730, source-of-injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or services;

"(d) Determination that a health care item or service is experimental, investigational or not medically necessary, effective or appropriate; or

"(e) Determination that a course or plan of treatment that an enrollee is undergoing is an active course of treatment for purposes of continuity of care under ORS 743.854.

"(2) 'Authorized representative' means an individual who by law or by the consent of a person may act on behalf of the person.

"**(3) 'Credit card' has the meaning given that term in 15 U.S.C. 1602.**

"(4) 'Electronic funds transfer' has the meaning given that term in ORS 293.525.

"[*(3)*] **(5)** 'Enrollee' has the meaning given that term in ORS 743.730.

"[*(4)*] **(6)** 'Grievance' means:

"(a) A communication from an enrollee or an authorized representative of an enrollee expressing dissatisfaction with an adverse benefit determination, without specifically declining any right to appeal or review, that is:

"(A) In writing, for an internal appeal or an external review; or

"(B) In writing or orally, for an expedited response described in ORS 743.804 (2)(d) or an expedited external review; or

"(b) A written complaint submitted by an enrollee or an authorized representative of an enrollee regarding the:

"(A) Availability, delivery or quality of a health care service;

"(B) Claims payment, handling or reimbursement for health care services and, unless the enrollee has not submitted a request for an internal appeal, the complaint is not disputing an adverse benefit determination; or

"(C) Matters pertaining to the contractual relationship between an

enrollee and an insurer.

"[*(5)*] **(7)** 'Health benefit plan' has the meaning given that term in ORS 743.730.

"[*(6)*] **(8)** 'Independent practice association' means a corporation wholly owned by providers, or whose membership consists entirely of providers, formed for the sole purpose of contracting with insurers for the provision of health care services to enrollees, or with employers for the provision of health care services to employees, or with a group, as described in ORS 731.098, to provide health care services to group members.

"[*(7)*] **(9)** 'Insurer' includes a health care service contractor as defined in ORS 750.005.

"[*(8)*] **(10)** 'Internal appeal' means a review by an insurer of an adverse benefit determination made by the insurer.

"[*(9)*] **(11)** 'Managed health insurance' means any health benefit plan that:

"(a) Requires an enrollee to use a specified network or networks of providers managed, owned, under contract with or employed by the insurer in order to receive benefits under the plan, except for emergency or other specified limited service; or

"(b) In addition to the requirements of paragraph (a) of this subsection, offers a point-of-service provision that allows an enrollee to use providers outside of the specified network or networks at the option of the enrollee and receive a reduced level of benefits.

"[*(10)*] **(12)** 'Medical services contract' means a contract between an insurer and an independent practice association, between an insurer and a provider, between an independent practice association and a provider or organization of providers, between medical or mental health clinics, and between a medical or mental health clinic and a provider to provide medical or mental health services. 'Medical services contract' does not include a contract of employment or a contract creating legal entities and ownership thereof that are authorized under ORS chapter 58, 60 or 70, or other similar

professional organizations permitted by statute.

"[*(11)(a)*] **(13)(a)** 'Preferred provider organization insurance' means any health benefit plan that:

"(A) Specifies a preferred network of providers managed, owned or under contract with or employed by an insurer;

"(B) Does not require an enrollee to use the preferred network of providers in order to receive benefits under the plan; and

"(C) Creates financial incentives for an enrollee to use the preferred network of providers by providing an increased level of benefits.

"(b) 'Preferred provider organization insurance' does not mean a health benefit plan that has as its sole financial incentive a hold harmless provision under which providers in the preferred network agree to accept as payment in full the maximum allowable amounts that are specified in the medical services contracts.

"[*(12)*] **(14)** 'Prior authorization' means a determination by an insurer prior to provision of services that the insurer will provide reimbursement for the services. 'Prior authorization' does not include referral approval for evaluation and management services between providers.

"[*(13)*] **(15)(a)** 'Provider' means a person licensed, certified or otherwise authorized or permitted by laws of this state to administer medical or mental health services in the ordinary course of business or practice of a profession.

"**(b) With respect to the statutes governing the billing for or payment of claims, 'provider' also includes an employee or other designee of the provider who has the responsibility for billing claims for reimbursement or receiving payments on claims.**

"[*(14)*] **(16)** 'Utilization review' means a set of formal techniques used by an insurer or delegated by the insurer designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services, procedures or settings.

"SECTION 3. ORS 743.801, as amended by section 3, chapter 596, Oregon

Laws 2013, is amended to read:

"743.801. As used in this section and ORS 743.065, 743.803, 743.804, 743.806, 743.807, 743.808, 743.811, 743.814, 743.817, 743.819, 743.821, 743.823, 743.827, 743.829, 743.831, 743.834, 743.837, 743.839, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.894, 743.911, 743.912, 743.913, 743.917 and 743.918:

"(1) 'Adverse benefit determination' means an insurer's denial, reduction or termination of a health care item or service, or an insurer's failure or refusal to provide or to make a payment in whole or in part for a health care item or service, that is based on the insurer's:

"(a) Denial of eligibility for or termination of enrollment in a health benefit plan;

"(b) Rescission or cancellation of a policy or certificate;

"(c) Imposition of a preexisting condition exclusion as defined in ORS 743.730, source-of-injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or services;

"(d) Determination that a health care item or service is experimental, investigational or not medically necessary, effective or appropriate; or

"(e) Determination that a course or plan of treatment that an enrollee is undergoing is an active course of treatment for purposes of continuity of care under ORS 743.854.

"(2) 'Authorized representative' means an individual who by law or by the consent of a person may act on behalf of the person.

"**(3) 'Credit card' has the meaning given that term in 15 U.S.C. 1602.**

"(4) 'Electronic funds transfer' has the meaning given that term in ORS 293.525.

"[*(3)*] **(5)** 'Enrollee' has the meaning given that term in ORS 743.730.

"[*(4)*] **(6)** 'Grievance' means:

"(a) A communication from an enrollee or an authorized representative of an enrollee expressing dissatisfaction with an adverse benefit determi-

nation, without specifically declining any right to appeal or review, that is:

"(A) In writing, for an internal appeal or an external review; or

"(B) In writing or orally, for an expedited response described in ORS 743.804 (2)(d) or an expedited external review; or

"(b) A written complaint submitted by an enrollee or an authorized representative of an enrollee regarding the:

"(A) Availability, delivery or quality of a health care service;

"(B) Claims payment, handling or reimbursement for health care services and, unless the enrollee has not submitted a request for an internal appeal, the complaint is not disputing an adverse benefit determination; or

"(C) Matters pertaining to the contractual relationship between an enrollee and an insurer.

"[*(5)*] **(7)** 'Health benefit plan' has the meaning given that term in ORS 743.730.

"[*(6)*] **(8)** 'Independent practice association' means a corporation wholly owned by providers, or whose membership consists entirely of providers, formed for the sole purpose of contracting with insurers for the provision of health care services to enrollees, or with employers for the provision of health care services to employees, or with a group, as described in ORS 731.098, to provide health care services to group members.

"[*(7)*] **(9)** 'Insurer' includes a health care service contractor as defined in ORS 750.005.

"[*(8)*] **(10)** 'Internal appeal' means a review by an insurer of an adverse benefit determination made by the insurer.

"[*(9)*] **(11)** 'Managed health insurance' means any health benefit plan that:

"(a) Requires an enrollee to use a specified network or networks of providers managed, owned, under contract with or employed by the insurer in order to receive benefits under the plan, except for emergency or other specified limited service; or

"(b) In addition to the requirements of paragraph (a) of this subsection,

offers a point-of-service provision that allows an enrollee to use providers outside of the specified network or networks at the option of the enrollee and receive a reduced level of benefits.

"[*(10)*] **(12)** 'Medical services contract' means a contract between an insurer and an independent practice association, between an insurer and a provider, between an independent practice association and a provider or organization of providers, between medical or mental health clinics, and between a medical or mental health clinic and a provider to provide medical or mental health services. 'Medical services contract' does not include a contract of employment or a contract creating legal entities and ownership thereof that are authorized under ORS chapter 58, 60 or 70, or other similar professional organizations permitted by statute.

"[*(11)(a)*] **(13)(a)** 'Preferred provider organization insurance' means any health benefit plan that:

"(A) Specifies a preferred network of providers managed, owned or under contract with or employed by an insurer;

"(B) Does not require an enrollee to use the preferred network of providers in order to receive benefits under the plan; and

"(C) Creates financial incentives for an enrollee to use the preferred network of providers by providing an increased level of benefits.

"(b) 'Preferred provider organization insurance' does not mean a health benefit plan that has as its sole financial incentive a hold harmless provision under which providers in the preferred network agree to accept as payment in full the maximum allowable amounts that are specified in the medical services contracts.

"[*(12)*] **(14)** 'Prior authorization' means a determination by an insurer prior to provision of services that the insurer will provide reimbursement for the services. 'Prior authorization' does not include referral approval for evaluation and management services between providers.

"[*(13)*] **(15)(a)** 'Provider' means a person licensed, certified or otherwise

authorized or permitted by laws of this state to administer medical or mental health services in the ordinary course of business or practice of a profession.

"**(b) With respect to the statutes governing the billing for or payment of claims, 'provider' also includes an employee or other designee of the provider who has the responsibility for billing claims for reimbursement or receiving payments on claims.**

"[*(14)*] **(16)** 'Utilization review' means a set of formal techniques used by an insurer or delegated by the insurer designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services, procedures or settings.

"SECTION 4. ORS 743.804 is amended to read:

"743.804. All insurers offering a health benefit plan in this state shall:

"(1) Provide to all enrollees directly or in the case of a group policy to the employer or other policyholder for distribution to enrollees, to all applicants, and to prospective applicants upon request, the following information:

"(a) The insurer's written policy on the rights of enrollees, including the right:

"(A) To participate in decision making regarding the enrollee's health care.

"(B) To be treated with respect and with recognition of the enrollee's dignity and need for privacy.

"(C) To have grievances handled in accordance with this section.

"(D) To be provided with the information described in this section.

"(b) An explanation of the procedures described in subsection (2) of this section for making coverage determinations and resolving grievances. The explanation must be culturally and linguistically appropriate, as prescribed by the department by rule, and must include:

"(A) The procedures for requesting an expedited response to an internal appeal under subsection (2)(d) of this section or for requesting an expedited

external review of an adverse benefit determination;

"(B) A statement that if an insurer does not comply with the decision of an independent review organization under ORS 743.862, the enrollee may sue the insurer under ORS 743.864;

"(C) The procedure to obtain assistance available from the insurer, if any, and from the Department of Consumer and Business Services in filing grievances; and

"(D) A description of the process for filing a complaint with the department.

"(c) A summary of benefits and an explanation of coverage in a form and manner prescribed by the department by rule.

"(d) A summary of the insurer's policies on prescription drugs, including:

"(A) Cost-sharing differentials;

"(B) Restrictions on coverage;

"(C) Prescription drug formularies;

"(D) Procedures by which a provider with prescribing authority may prescribe drugs not included on the formulary;

"(E) Procedures for the coverage of prescription drugs not included on the formulary; and

"(F) A summary of the criteria for determining whether a drug is experimental or investigational.

"(e) A list of network providers and how the enrollee can obtain current information about the availability of providers and how to access and schedule services with providers, including clinic and hospital networks.

"(f) Notice of the enrollee's right to select a primary care provider and specialty care providers.

"(g) How to obtain referrals for specialty care in accordance with ORS 743.856.

"(h) Restrictions on services obtained outside of the insurer's network or service area.

"(i) The availability of continuity of care as required by ORS 743.854.

"(j) Procedures for accessing after-hours care and emergency services as required by ORS 743A.012.

"(k) Cost-sharing requirements and other charges to enrollees.

"(L) Procedures, if any, for changing providers.

"(m) Procedures, if any, by which enrollees may participate in the development of the insurer's corporate policies.

"(n) A summary of how the insurer makes decisions regarding coverage and payment for treatment or services, including a general description of any prior authorization and utilization control requirements that affect coverage or payment.

"(o) Disclosure of any risk-sharing arrangement the insurer has with physicians or other providers.

"(p) A summary of the insurer's procedures for protecting the confidentiality of medical records and other enrollee information.

"(q) An explanation of assistance provided to non-English-speaking enrollees.

"(r) Notice of the information available from the department that is filed by insurers as required under ORS 743.807, 743.814 and 743.817.

"(2) Establish procedures for making coverage determinations and resolving grievances that provide for all of the following:

"(a) Timely notice of adverse benefit determinations in a form and manner approved by the department or prescribed by the department by rule.

"(b) A method for recording all grievances, including the nature of the grievance and significant action taken.

"(c) Written decisions meeting criteria established by the Director of the Department of Consumer and Business Services by rule.

"(d) An expedited response to a request for an internal appeal that accommodates the clinical urgency of the situation.

"(e) At least one but not more than two levels of internal appeal for group

health benefit plans and one level of internal appeal for individual health benefit plans. If an insurer provides:

"(A) Two levels of internal appeal, a person who was involved in the consideration of the initial denial or the first level of internal appeal may not be involved in the second level of internal appeal; and

"(B) No more than one level of internal appeal, a person who was involved in the consideration of the initial denial may not be involved in the internal appeal.

"(f)(A) An external review that meets the requirements of ORS 743.857, 743.859 and 743.861 and is conducted in a manner approved by the department or prescribed by the department by rule, after the enrollee has exhausted internal appeals or after the enrollee has been deemed to have exhausted internal appeals.

"(B) An enrollee shall be deemed to have exhausted internal appeals if an insurer fails to strictly comply with this section and federal requirements for internal appeals.

"(g) The opportunity for the enrollee to receive continued coverage of an approved and ongoing course of treatment under the health benefit plan pending the conclusion of the internal appeal process.

"(h) The opportunity for the enrollee or any authorized representative chosen by the enrollee to:

"(A) Submit for consideration by the insurer any written comments, documents, records and other materials relating to the adverse benefit determination; and

"(B) Receive from the insurer, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the adverse benefit determination.

"(3) Establish procedures for notifying affected enrollees of:

"(a) A change in or termination of any benefit; and

"(b)(A) The termination of a primary care delivery office or site; and

"(B) Assistance available to enrollees in selecting a new primary care delivery office or site.

"(4) Provide the information described in subsection (2) of this section and ORS 743.859 at each level of internal appeal to an enrollee who is notified of an adverse benefit determination or to an enrollee who files a grievance.

"(5) Upon the request of an enrollee, applicant or prospective applicant, provide:

"(a) The insurer's annual report on grievances and internal appeals submitted to the department under subsection (8) of this section.

"(b) A description of the insurer's efforts, if any, to monitor and improve the quality of health services.

"(c) Information about the insurer's procedures for credentialing network providers.

"(6) Provide, upon the request of an enrollee, a written summary of information that the insurer may consider in its utilization review of a particular condition or disease, to the extent the insurer maintains such criteria. Nothing in this subsection requires an insurer to advise an enrollee how the insurer would cover or treat that particular enrollee's disease or condition. Utilization review criteria that are proprietary shall be subject to oral disclosure only.

"(7) Maintain for a period of at least six years written records that document all grievances described in ORS 743.801 [*(4)(a)*] **(6)(a)** and make the written records available for examination by the department or by an enrollee or authorized representative of an enrollee with respect to a grievance made by the enrollee. The written records must include but are not limited to the following:

"(a) Notices and claims associated with each grievance.

"(b) A general description of the reason for the grievance.

"(c) The date the grievance was received by the insurer.

"(d) The date of the internal appeal or the date of any internal appeal

meeting held concerning the appeal.

"(e) The result of the internal appeal at each level of appeal.

"(f) The name of the covered person for whom the grievance was submitted.

"(8) Provide an annual summary to the department of the insurer's aggregate data regarding grievances, internal appeals and requests for external review in a format prescribed by the department to ensure consistent reporting on the number, nature and disposition of grievances, internal appeals and requests for external review.

"(9) Allow the exercise of any rights described in this section by an authorized representative.".