House Bill 2341

Introduced and printed pursuant to House Rule 12.00. Presession filed (at the request of Governor Kate Brown for Department of Consumer and Business Services)

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.**

Updates Insurance Code provisions applicable to health insurance in accordance with federal requirements.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to health insurance; amending ORS 743.551, 743A.100, 743A.104, 743A.105, 743A.108, 743A.141, 743B.001, 743B.005, 743B.120, 743B.250, 743B.252, 743B.505 and 743B.800; and declaring an emergency.

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

SECTION 1. ORS 743.551 is amended to read:

743.551. (1) As used in this section, "student health benefit plan" means a plan that is subject to rules adopted by the United States Department of Health and Human Services under 42 U.S.C. 18118(c).

(2) Notwithstanding any other provision of law, the Department of Consumer and Business Services shall by rule and in a manner consistent with federal law **in effect on January 1, 2017**, adopt requirements for student health benefit plans.

SECTION 2. ORS 743A.100 is amended to read:

743A.100. (1) Every health insurance policy that covers hospital, medical or surgical expenses, other than coverage limited to expenses from accidents or specific diseases, shall provide coverage of mammograms as follows:

(a) Mammograms for the purpose of diagnosis in symptomatic or high-risk [*women*] **individuals** at any time upon referral of [*the woman's*] **an individual's** health care provider; and

(b) An annual mammogram for the purpose of early detection for [*a woman*] **an individual** 40 years of age or older, with or without referral from the [*woman's*] **individual's** health care provider.

(2) An insurance policy described in subsection (1) of this section must not limit coverage of mammograms to the schedule provided in subsection (1) of this section if the [*woman*] **individual** is determined by [*her*] **the individual's** health care provider to be at high risk for breast cancer.

SECTION 3. ORS 743A.104 is amended to read:

743A.104. All policies providing health insurance, except those policies whose coverage is limited to expenses from accidents or specific diseases that are unrelated to the coverage required by this section, shall include coverage for pelvic examinations and Pap smear examinations as follows:

(1) Annually for [*women*] **individuals** 18 to 64 years of age; and

(2) At any time upon referral of [*the woman's*] **an individual's** health care provider.

SECTION 4. ORS 743A.105 is amended to read:

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.

743A.105. (1) All health benefit plans, as defined in ORS 743B.005, shall include coverage of the human papillomavirus vaccine for [*female*] beneficiaries under the health benefit plan who are at least 11 years of age but no older than 26 years of age.

(2) ORS 743A.001 does not apply to this section.

SECTION 5. ORS 743A.108 is amended to read:

743A.108. (1) A health insurance policy that covers hospital, medical or surgical expenses, other than coverage limited to expenses from accidents or specific diseases, shall provide coverage for a complete and thorough physical examination of the breast, including but not limited to a clinical breast examination, performed by a health care provider to check for lumps and other changes for the purpose of early detection and prevention of breast cancer as follows:

(a) Annually for [*women*] **individuals** 18 years of age and older; and

(b) At any time at the recommendation of [*the woman's*] **an individual's** health care provider.

(2) An insurance policy must provide coverage of physical examinations of the breast as described in subsection (1) of this section regardless of whether a health care provider performs other preventative [*women's*] health examinations or makes a referral for other preventative [*women's*] health examinations at the same time the health care provider performs the breast examination.

(3) This section applies to health care service contractors, as defined in ORS 750.005, and trusts carrying out a multiple employer welfare arrangement, as defined in ORS 750.301.

SECTION 6. ORS 743A.141 is amended to read:

743A.141. (1) As used in this section, "hearing aid" means any nondisposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments or accessory for the instrument or device, except batteries and cords.

(2) A health benefit plan, as defined in ORS 743B.005, shall provide payment, coverage or reimbursement for one hearing aid per hearing impaired ear if:

(a) Prescribed, fitted and dispensed by a licensed audiologist with the approval of a licensed physician; and

(b) Medically necessary for the treatment of hearing loss in an enrollee in the plan [*who is:*]

[*(A) 18 years of age or younger; or*]

[*(B) 19 to 25 years of age and enrolled in a secondary school or an accredited educational institution*].

(3)(a) The maximum benefit amount required by this section is [*$4,000*] **$4,744** every 48 months, but a health benefit plan may offer a benefit that is more favorable to the enrollee. An insurer shall adjust the benefit amount on January 1 of each year to reflect the increase since January 1, [*2010*] **2016**, in the U.S. City Average Consumer Price Index for All Urban Consumers for medical care as published by the Bureau of Labor Statistics of the United States Department of Labor.

(b) An insurer may not impose any financial or contractual penalty upon an audiologist if an enrollee elects to purchase a hearing aid priced higher than the benefit amount by paying the difference between the benefit amount and the price of the hearing aid.

(4) The payment, coverage or reimbursement required under this section may be subject to provisions of the health benefit plan that apply to other durable medical equipment benefits covered by the plan, including but not limited to provisions relating to deductibles, coinsurance and prior authorization.

(5) This section is exempt from ORS 743A.001.

SECTION 7. ORS 743B.001, as amended by sections 3 and 4, chapter 59, Oregon Laws 2015, is amended to read:

743B.001. As used in this section and ORS 743.008, 743.035, 743B.195, 743B.197, 743B.200, 743B.202, 743B.204, 743B.206, 743B.220, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.310, 743B.400, 743B.403, 743B.405, 743B.420, 743B.422, 743B.423, 743B.424, 743B.450, 743B.451, 743B.452, 743B.453, 743B.454, 743B.505, 743B.550 and 743B.555:

(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 743B.005, 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 743B.225**; or**

(f) Applying a treatment limitation on the reimbursement of mental health or substance abuse disorder services that is more restrictive than the predominant treatment limitations applied to medical and surgical services reimbursed by the insurer.

(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.

(5) "Enrollee" has the meaning given that term in ORS 743B.005.

(6) "Essential community provider" has the meaning given that term in rules**, in effect on January 1, 2017,** 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.

(7) "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 743B.250 (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.

(8) "Health benefit plan" has the meaning given that term in ORS 743B.005.

(9) "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.

(10) "Insurer" includes a health care service contractor as defined in ORS 750.005.

(11) "Internal appeal" means a review by an insurer of an adverse benefit determination made by the insurer.

(12) "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.

(13) "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.

(14)(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.

(15) "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.

(16)(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.

(17) "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 8. ORS 743B.005 is amended to read:

743B.005. For purposes of ORS 743.004, 743.007, 743.022, 743.535, 743B.003 to 743B.127 and 743B.128:

(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Director of the Department of Consumer and Business Services that a carrier is in compliance with the provisions of ORS 743B.012 based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the carrier in establishing premium rates for small employer health benefit plans.

(2) "Affiliate" of, or person "affiliated" with, a specified person means any carrier who, directly or indirectly through one or more intermediaries, controls or is controlled by or is under common control with a specified person. For purposes of this definition, "control" has the meaning given that term in ORS 732.548.

(3) "Affiliation period" means, under the terms of a group health benefit plan issued by a health care service contractor, a period:

(a) That is applied uniformly and without regard to any health status related factors to an enrollee or late enrollee;

(b) That must expire before any coverage becomes effective under the plan for the enrollee or late enrollee;

(c) During which no premium shall be charged to the enrollee or late enrollee; and

(d) That begins on the enrollee's or late enrollee's first date of eligibility for coverage and runs concurrently with any eligibility waiting period under the plan.

(4) "Bona fide association" means an association that:

(a) Has been in active existence for at least five years;

(b) Has been formed and maintained in good faith for purposes other than obtaining insurance;

(c) Does not condition membership in the association on any factor relating to the health status of an individual or the individual's dependent or employee;

(d) Makes health insurance coverage that is offered through the association available to all members of the association regardless of the health status of the member or individuals who are eligible for coverage through the member;

(e) Does not make health insurance coverage that is offered through the association available other than in connection with a member of the association;

(f) Has a constitution and bylaws; and

(g) Is not owned or controlled by a carrier, producer or affiliate of a carrier or producer.

(5) "Carrier" means any person who provides health benefit plans in this state, including:

(a) A licensed insurance company;

(b) A health care service contractor;

(c) A health maintenance organization;

(d) An association or group of employers that provides benefits by means of a multiple employer welfare arrangement and that:

(A) Is subject to ORS 750.301 to 750.341; or

(B) Is fully insured and otherwise exempt under ORS 750.303 (4) but elects to be governed by ORS 743B.010 to 743B.013; or

(e) Any other person or corporation responsible for the payment of benefits or provision of services.

(6) "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health benefit plan covering the employee.

(7) "Eligible employee" means an employee who is eligible for coverage under a group health benefit plan.

(8) "Employee" means any individual employed by an employer.

(9) "Enrollee" means an employee, dependent of the employee or an individual otherwise eligible for a group or individual health benefit plan who has enrolled for coverage under the terms of the plan.

(10) "Exchange" means an American Health Benefit Exchange described in 42 U.S.C. 18031, 18032, 18033 and 18041.

(11) "Exclusion period" means a period during which specified treatments or services are excluded from coverage.

(12) "Financial impairment" means that a carrier is not insolvent and is:

(a) Considered by the director to be potentially unable to fulfill its contractual obligations; or

(b) Placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(13)(a) "Geographic average rate" means the arithmetical average of the lowest premium and the corresponding highest premium to be charged by a carrier in a geographic area established by the director for the carrier's:

(A) Group health benefit plans offered to small employers; or

(B) Individual health benefit plans.

(b) "Geographic average rate" does not include premium differences that are due to differences in benefit design, age, tobacco use or family composition.

(14) "Grandfathered health plan" has the meaning prescribed by **rule by** the United States Secretaries of Labor, Health and Human Services and the Treasury pursuant to 42 U.S.C. 18011(e) **that is in effect on January 1, 2017**.

(15) "Group eligibility waiting period" means, with respect to a group health benefit plan, the period of employment or membership with the group that a prospective enrollee must complete before plan coverage begins.

(16)(a) "Health benefit plan" means any:

(A) Hospital expense, medical expense or hospital or medical expense policy or certificate;

(B) Subscriber contract of a health care service contractor as defined in ORS 750.005; or

(C) Plan provided by a multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended, to the extent that the plan is subject to state regulation.

(b) "Health benefit plan" does not include:

(A) Coverage for accident only, specific disease or condition only, credit or disability income;

(B) Coverage of Medicare services pursuant to contracts with the federal government;

(C) Medicare supplement insurance policies;

(D) Coverage of TRICARE services pursuant to contracts with the federal government;

(E) Benefits delivered through a flexible spending arrangement established pursuant to section 125 of the Internal Revenue Code of 1986, as amended, when the benefits are provided in addition to a group health benefit plan;

(F) Separately offered long term care insurance, including, but not limited to, coverage of nursing home care, home health care and community-based care;

(G) Independent, noncoordinated, hospital-only indemnity insurance or other fixed indemnity in-

surance;

(H) Short term health insurance policies that are in effect for periods of 12 months or less, including the term of a renewal of the policy;

(I) Dental only coverage;

(J) Vision only coverage;

(K) Stop-loss coverage that meets the requirements of ORS 742.065;

(L) Coverage issued as a supplement to liability insurance;

(M) Insurance arising out of a workers' compensation or similar law;

(N) Automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance; or

(O) Any employee welfare benefit plan that is exempt from state regulation because of the federal Employee Retirement Income Security Act of 1974, as amended.

(c) For purposes of this subsection, renewal of a short term health insurance policy includes the issuance of a new short term health insurance policy by an insurer to a policyholder within 60 days after the expiration of a policy previously issued by the insurer to the policyholder.

(17) "Individual health benefit plan" means a health benefit plan:

(a) That is issued to an individual policyholder; or

(b) That provides individual coverage through a trust, association or similar group, regardless of the situs of the policy or contract.

(18) "Initial enrollment period" means a period of at least 30 days following commencement of the first eligibility period for an individual.

(19) "Late enrollee" means an individual who enrolls in a group health benefit plan subsequent to the initial enrollment period during which the individual was eligible for coverage but declined to enroll. However, an eligible individual shall not be considered a late enrollee if:

(a) The individual qualifies for a special enrollment period in accordance with 42 U.S.C. 300gg or as prescribed by rule by the Department of Consumer and Business Services;

(b) The individual applies for coverage during an open enrollment period;

(c) A court issues an order that coverage be provided for a spouse or minor child under an employee's employer sponsored health benefit plan and request for enrollment is made within 30 days after issuance of the court order;

(d) The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period; or

(e) The individual's coverage under Medicaid, Medicare, TRICARE, Indian Health Service or a publicly sponsored or subsidized health plan, including, but not limited to, the medical assistance program under ORS chapter 414, has been involuntarily terminated within 63 days after applying for coverage in a group health benefit plan.

(20) "Multiple employer welfare arrangement" means a multiple employer welfare arrangement as defined in section 3 of the federal Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. 1002, that is subject to ORS 750.301 to 750.341.

(21) "Preexisting condition exclusion" means:

(a) Except for a grandfathered health plan, a limitation or exclusion of benefits or a denial of coverage based on a medical condition being present before the effective date of coverage or before the date coverage is denied, whether or not any medical advice, diagnosis, care or treatment was recommended or received for the condition before the date of coverage or denial of coverage.

(b) With respect to a grandfathered health plan, a provision applicable to an enrollee or late enrollee that excludes coverage for services, charges or expenses incurred during a specified period immediately following enrollment for a condition for which medical advice, diagnosis, care or treatment was recommended or received during a specified period immediately preceding enrollment. For purposes of this paragraph pregnancy and genetic information do not constitute preexisting conditions.

(22) "Premium" includes insurance premiums or other fees charged for a health benefit plan, including the costs of benefits paid or reimbursements made to or on behalf of enrollees covered by the plan.

(23) "Rating period" means the 12-month calendar period for which premium rates established by a carrier are in effect, as determined by the carrier.

(24) "Representative" does not include an insurance producer or an employee or authorized representative of an insurance producer or carrier.

(25) "Small employer" has the meaning given that term in 42 U.S.C. 18024 [*unless otherwise prescribed by the department by rule in accordance with guidance issued by the United States Department of Health and Human Services, the United States Department of Labor or the United States Department of the Treasury*] **as amended and in effect on January 1, 2017**.

SECTION 9. ORS 743B.120 is amended to read:

743B.120. Notwithstanding any other provision of law, a health benefit plan that is not a grandfathered health plan:

(1) Must provide coverage of preventive health services as prescribed by the United States Department of Health and Human Services pursuant to 42 U.S.C. 300gg-13 **in rules adopted and in effect on January 1, 2017**; and

(2) May not impose cost-sharing requirements on an enrollee for preventive health services, except as allowed by federal law.

SECTION 10. ORS 743B.250, as amended by section 5, chapter 59, Oregon Laws 2015, is amended to read:

743B.250. 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 743B.256, the enrollee may sue the insurer under ORS 743B.258;

(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 **clinically appropriate** drugs not included on the formulary;

(E) Procedures for the coverage of **clinically appropriate** 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. The list must be available online and upon request in printed format.

(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 743B.227.

(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 743B.225.

(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 and the requirement under ORS 743B.555 that a carrier or third party administrator send communications containing protected health information only to the enrollee who is the subject of the protected health 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 743B.200, 743B.202 and 743B.423.

(2) Establish procedures**, in accordance with requirements adopted by the department,** 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 **and for any denial of an exception to a prescription drug formulary**. 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 743B.252, 743B.254 and 743B.255 [*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 743B.254 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 de-

scribed in ORS 743B.001 (7)(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.

SECTION 11. ORS 743B.252 is amended to read:

743B.252. (1) An insurer offering health benefit plans in this state shall have an external review program that meets the requirements of this section and ORS 743B.255 and rules adopted by the Director of the Department of Consumer and Business Services to carry out the provisions of this section and ORS **743B.250 and** 743B.255. Each insurer shall provide the external review through an independent review organization that is under contract with the director to provide external review. Each health benefit plan must allow an enrollee, by applying to the insurer or the director, to obtain review by an independent review organization of a dispute relating to an adverse benefit determination by the insurer on one or more of the following:

(a) Whether a course or plan of treatment is medically necessary.

(b) Whether a course or plan of treatment is experimental or investigational.

(c) Whether 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 743B.225.

(d) Whether a course or plan of treatment is delivered in an appropriate health care setting and with the appropriate level of care.

(e) Whether an exception to the health benefit plan's prescription drug formulary should be granted.

(2) An insurer shall incur all costs of its external review program. The insurer may not establish or charge a fee payable by enrollees for conducting external review.

(3) When an enrollee applies for external review, the director shall appoint an independent review organization. When an independent review organization is appointed, the insurer shall forward all medical records and other relevant materials to the independent review organization no later than five business days after the appointment. The insurer shall produce additional information as requested by the independent review organization to the extent that the information is reasonably available to the insurer. An independent review organization may reverse the adverse benefit determination if the insurer fails to furnish records, information and materials to the independent review organization in a timely manner.

(4) An enrollee may submit additional information to the independent review organization no later than five business days after the enrollee's receipt of notification of the appointment of the independent review organization and the organization must consider the information in its review.

(5) The insurer and the director shall expedite the external review:

(a) If the adverse benefit determination concerns an admission, the availability of care, a continued stay or a health care service for a medical condition for which the enrollee received emergency services, as defined in ORS 743A.012, and has not been discharged from a health care facility; or

(b) If a provider with an established clinical relationship to the enrollee certifies in writing and provides supporting documentation that the ordinary time period for external review would seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

SECTION 12. ORS 743B.505 is amended to read:

743B.505. (1) An insurer offering a health benefit plan in this state that provides coverage to individuals or to small employers, as defined in ORS 743B.005, through a specified network of health care providers shall:

(a) Contract with or employ a network of providers that is sufficient in number, geographic distribution and types of providers to ensure that all covered services under the health benefit plan, including mental health and substance abuse treatment, are accessible to enrollees without unreasonable delay.

(b)(A) With respect to health benefit plans offered through the health insurance exchange under ORS 741.310, contract with a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of essential community providers for low-income, medically underserved individuals in the plan's service area in accordance with the network adequacy standards established by the Department of Consumer and Business Services;

(B) If the health benefit plan offered through the health insurance exchange offers a majority of the covered services through physicians employed by the insurer or through a single contracted medical group, have a sufficient number and geographic distribution of employed or contracted providers and hospital facilities to ensure reasonable and timely access for low-income, medically underserved enrollees in the plan's service area, in accordance with network adequacy standards adopted by the Department of Consumer and Business Services; or

(C) With respect to health benefit plans offered outside of the health insurance exchange, contract with or employ a network of providers that is sufficient in number, geographic distribution and types of providers to ensure 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.

(c) Annually report to the Department of Consumer and Business Services, in the format prescribed by the department, the insurer's plan for ensuring that the network of providers for each health benefit plan meets the requirements of this section.

(2)(a) An insurer may not discriminate with respect to participation under a health benefit plan or coverage under the plan against any health care provider who is acting within the scope of the provider's license or certification in this state.

(b) This subsection does not require an insurer to contract with any health care provider who is willing to abide by the insurer's terms and conditions for participation established by the insurer.

(c) This subsection does not prevent an insurer from establishing varying reimbursement rates based on quality or performance measures.

(d) Rules adopted by the Department of Consumer and Business Services to implement this sec-

tion shall be consistent with the provisions of 42 U.S.C. 300gg-5 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. 300gg-5 **that are in effect on January 1, 2017**.

(3) The Department of Consumer and Business Services shall use one of the following methods in evaluating whether the network of providers available to enrollees in a health benefit plan meets the requirements of this section:

(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.

(4) This section does not require an insurer to contract with an essential community provider that refuses to accept the insurer's generally applicable payment rates for services covered by the plan.

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

SECTION 13. ORS 743B.800 is amended to read:

743B.800. (1) As used in this section, "health benefit plan" means a health benefit plan, as defined in ORS 743B.005, that is offered in the individual or small group market.

(2) The Department of Consumer and Business Services may establish by rule a procedure for adjusting risk between insurers. If a procedure is established, the procedure may include:

(a) An assessment imposed on an insurer if the actuarial risk of the enrollees in the insurer's health benefit plans is less than the average actuarial risk of all enrollees in all health benefit plans in this state; and

(b) Payments to insurers if the actuarial risk of the enrollees in the insurer's health benefit plans is greater than the average actuarial risk of all enrollees in all health benefit plans in this state.

(3) A procedure established under this section must be consistent with 42 U.S.C. 18063 and regulations adopted by the Secretary of the United States Department of Health and Human Services to carry out 42 U.S.C. 18063 **that are in effect on January 1, 2017**.

SECTION 14. This 2017 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2017 Act takes effect on its passage.
