

A-Engrossed
Senate Bill 249

Ordered by the Senate February 25
Including Senate Amendments dated February 25

Printed pursuant to Senate Interim Rule 213.28 by order of the President of the Senate in conformance with pre-session filing rules, indicating neither advocacy nor opposition on the part of the President (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.

Specifies requirements for insurer determinations regarding requests for prior authorization for coverage of health care items, services, procedures and settings.

A BILL FOR AN ACT

1
2 Relating to prior authorization determinations; creating new provisions; and amending ORS
3 743A.067, 743A.168, 743A.264, 743B.001, 743B.250, 743B.422, 743B.423 and 746.230 and section 2,
4 chapter 771, Oregon Laws 2013.

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

6 **SECTION 1. Section 2 of this 2019 Act is added to and made a part of the Insurance Code.**

7 **SECTION 2. (1) As used in this section, "prior authorization" has the meaning given that**
8 **term in ORS 743B.001.**

9 **(2) An insurer offering a policy or certificate of health insurance may not, in making a**
10 **determination on a health care provider or enrollee's request for prior authorization of a**
11 **health care item or service, perform any of the following unfair claim settlement practices:**

12 **(a) Misrepresent facts of policy provisions;**

13 **(b) Fail to acknowledge and act upon communications relating to the request;**

14 **(c) Fail to adopt and implement reasonable standards for the prompt investigations of**
15 **prior authorization requests;**

16 **(d) Make a determination without conducting a reasonable investigation based on all**
17 **available information;**

18 **(e) Fail to act promptly, equitably and in good faith to approve the request for prior au-**
19 **thorization that is medically necessary and covered under the terms of the policy;**

20 **(f) Require a provider or enrollee to submit substantially identical information more than**
21 **one time in the course of making the determination; or**

22 **(g) If the request for prior authorization is denied, fail to promptly provide a complete**
23 **and thorough explanation of the terms of the policy or certificate that the insurer relied**
24 **upon and the factual or legal basis for the denial.**

25 **(3) An insurer may not engage in a pattern or practice of refusing, without just cause,**
26 **to approve requests for prior authorization of items or services covered under its policies**
27 **and certificates as demonstrated by:**

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.

1 (a) A substantial increase in the number of consumer complaints against the insurer
2 received by the Department of Consumer and Business Services regarding denials of prior
3 authorization;

4 (b) A substantial number of lawsuits filed by:

5 (A) A provider against the insurer or an insured based on the failure to approve a request
6 for prior authorization for an item or service furnished by the provider; or

7 (B) A provider or enrollee against the insurer based on the failure to approve a prior
8 authorization request for an item or service; or

9 (c) Other evidence that the department deems relevant.

10 (4) The department may adopt rules necessary to carry out the provisions of this section.

11 **SECTION 3.** ORS 743B.422 is amended to read:

12 743B.422. All utilization review performed pursuant to a medical services contract to which an
13 insurer is not a party shall comply with the following:

14 (1) The criteria used in the review process and the method of development of the criteria shall
15 be made available for review to a party to such medical services contract upon request.

16 (2) A physician licensed under ORS 677.100 to 677.228 shall be responsible for all final recom-
17 mendations regarding the necessity or appropriateness of services or the site at which the services
18 are provided and shall consult as appropriate with medical and mental health specialists in making
19 such recommendations.

20 (3) Any patient or provider who has had a request for treatment or payment for services denied
21 as not medically necessary or as experimental shall be provided an opportunity for a timely appeal
22 before an appropriate medical consultant or peer review committee.

23 (4) [A provider] **Except as provided in subsection (5) of this section, a determination on a**
24 **provider's or an enrollee's** request for prior authorization of a nonemergency service must be
25 [answered] **issued within a reasonable period of time appropriate to the medical circumstances**
26 **but no later than two business days after receipt of the request**, and qualified health care per-
27 sonnel must be available for same-day telephone responses to inquiries concerning certification of
28 continued length of stay.

29 (5) **If additional information from an enrollee or a provider is necessary to make a de-**
30 **termination on a request for prior authorization, no later than two business days after re-**
31 **ceipt of the request, the enrollee and the provider shall be notified in writing of the specific**
32 **additional information needed to make the determination. The determination must be issued**
33 **by the later of:**

34 (a) **Two business days after receipt of a response to the request for additional informa-**
35 **tion; or**

36 (b) **Fifteen days after the date of the request for additional information.**

37 **SECTION 4.** ORS 743B.423 is amended to read:

38 743B.423. (1) All insurers offering a health benefit plan in this state that provide utilization re-
39 view or have utilization review provided on their behalf shall file an annual summary with the De-
40 partment of Consumer and Business Services that describes all utilization review policies, including
41 delegated utilization review functions, and documents the insurer's procedures for monitoring of
42 utilization review activities.

43 (2) All utilization review activities conducted pursuant to subsection (1) of this section shall
44 comply with the following:

45 (a) The criteria used in the utilization review process and the method of development of the

1 criteria shall be made available for review to contracting providers upon request.

2 (b) A physician licensed under ORS 677.100 to 677.228 shall be responsible for all final recom-
3 mendations regarding the necessity or appropriateness of services or the site at which the services
4 are provided and shall consult as appropriate with medical and mental health specialists in making
5 such recommendations.

6 (c) Any provider who has had a request for treatment or payment for services denied as not
7 medically necessary or as experimental shall be provided an opportunity for a timely appeal before
8 an appropriate medical consultant or peer review committee.

9 (d) [A provider] **Except as provided in paragraph (e) of this subsection, an insurer must**
10 **issue a determination on a provider's or an enrollee's** request for prior authorization of a non-
11 emergency service [*must be answered*] within a **reasonable period of time appropriate to the**
12 **medical circumstances but no later than** two business days **after receipt of the request**, and
13 qualified health care personnel must be available for same-day telephone responses to inquiries
14 concerning certification of continued length of stay.

15 (e) **If an insurer requires additional information from an enrollee or a provider to make**
16 **a determination on a request for prior authorization, no later than two business days after**
17 **receipt of the request, the insurer shall notify the enrollee and the provider in writing of the**
18 **additional information needed to make the determination. The insurer shall issue the deter-**
19 **mination by the later of:**

20 (A) **Two business days after receipt of a response to the request for additional informa-**
21 **tion; or**

22 (B) **Fifteen days after the date of the request for additional information.**

23 **SECTION 5.** ORS 743A.067 is amended to read:

24 743A.067. (1) As used in this section:

25 (a) "Contraceptives" means health care services, drugs, devices, products or medical procedures
26 to prevent a pregnancy.

27 (b) "Enrollee" means an insured individual and the individual's spouse, domestic partner and
28 dependents who are beneficiaries under the insured individual's health benefit plan.

29 (c) "Health benefit plan" has the meaning given that term in ORS 743B.005, excluding Medicare
30 Advantage Plans and including health benefit plans offering pharmacy benefits administered by a
31 third party administrator or pharmacy benefit manager.

32 (d) **"Prior authorization" has the meaning given that term in ORS 743B.001.**

33 [(d)] (e) "Religious employer" has the meaning given that term in ORS 743A.066.

34 (f) **"Utilization review" has the meaning given that term in ORS 743B.001.**

35 (2) A health benefit plan offered in this state must provide coverage for all of the following
36 services, drugs, devices, products and procedures:

37 (a) Well-woman care prescribed by the Department of Consumer and Business Services by rule
38 consistent with guidelines published by the United States Health Resources and Services Adminis-
39 tration.

40 (b) Counseling for sexually transmitted infections, including but not limited to human
41 immunodeficiency virus and acquired immune deficiency syndrome.

42 (c) Screening for:

43 (A) Chlamydia;

44 (B) Gonorrhea;

45 (C) Hepatitis B;

- 1 (D) Hepatitis C;
- 2 (E) Human immunodeficiency virus and acquired immune deficiency syndrome;
- 3 (F) Human papillomavirus;
- 4 (G) Syphilis;
- 5 (H) Anemia;
- 6 (I) Urinary tract infection;
- 7 (J) Pregnancy;
- 8 (K) Rh incompatibility;
- 9 (L) Gestational diabetes;
- 10 (M) Osteoporosis;
- 11 (N) Breast cancer; and
- 12 (O) Cervical cancer.

13 (d) Screening to determine whether counseling related to the BRCA1 or BRCA2 genetic
14 mutations is indicated and counseling related to the BRCA1 or BRCA2 genetic mutations if indi-
15 cated.

16 (e) Screening and appropriate counseling or interventions for:

- 17 (A) Tobacco use; and
- 18 (B) Domestic and interpersonal violence.

19 (f) Folic acid supplements.

20 (g) Abortion.

21 (h) Breastfeeding comprehensive support, counseling and supplies.

22 (i) Breast cancer chemoprevention counseling.

23 (j) Any contraceptive drug, device or product approved by the United States Food and Drug
24 Administration, subject to all of the following:

25 (A) If there is a therapeutic equivalent of a contraceptive drug, device or product approved by
26 the United States Food and Drug Administration, a health benefit plan may provide coverage for
27 either the requested contraceptive drug, device or product or for one or more therapeutic equiv-
28 alents of the requested drug, device or product.

29 (B) If a contraceptive drug, device or product covered by the health benefit plan is deemed
30 medically inadvisable by the enrollee's provider, the health benefit plan must cover an alternative
31 contraceptive drug, device or product prescribed by the provider.

32 (C) A health benefit plan must pay pharmacy claims for reimbursement of all contraceptive
33 drugs available for over-the-counter sale that are approved by the United States Food and Drug
34 Administration.

35 (D) A health benefit plan may not infringe upon an enrollee's choice of contraceptive drug, de-
36 vice or product and may not require prior authorization, step therapy or other utilization [*control*]
37 **review** techniques for medically appropriate covered contraceptive drugs, devices or other products
38 approved by the United States Food and Drug Administration.

39 (k) Voluntary sterilization.

40 (L) As a single claim or combined with other claims for covered services provided on the same
41 day:

42 (A) Patient education and counseling on contraception and sterilization.

43 (B) Services related to sterilization or the administration and monitoring of contraceptive drugs,
44 devices and products, including but not limited to:

45 (i) Management of side effects;

1 (ii) Counseling for continued adherence to a prescribed regimen;

2 (iii) Device insertion and removal; and

3 (iv) Provision of alternative contraceptive drugs, devices or products deemed medically appropriate in the judgment of the enrollee's provider.

4
5 (m) Any additional preventive services for women that must be covered without cost sharing under 42 U.S.C. 300gg-13, as identified by the United States Preventive Services Task Force or the Health Resources and Services Administration of the United States Department of Health and Human Services as of January 1, 2017.

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9 (3) A health benefit plan may not impose on an enrollee a deductible, coinsurance, copayment or any other cost-sharing requirement on the coverage required by this section. A health care provider shall be reimbursed for providing the services described in this section without any deduction for coinsurance, copayments or any other cost-sharing amounts.

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12 (4) Except as authorized under this section, a health benefit plan may not impose any restrictions or delays on the coverage required by this section.

13
14 (5) This section does not exclude coverage for contraceptive drugs, devices or products prescribed by a provider, acting within the provider's scope of practice, for:

15
16 (a) Reasons other than contraceptive purposes, such as decreasing the risk of ovarian cancer or eliminating symptoms of menopause; or

17
18 (b) Contraception that is necessary to preserve the life or health of an enrollee.

19
20 (6) This section does not limit the authority of the Department of Consumer and Business Services to ensure compliance with ORS 743A.063 and 743A.066.

21
22 (7) This section does not require a health benefit plan to cover:

23 (a) Experimental or investigational treatments;

24 (b) Clinical trials or demonstration projects, except as provided in ORS 743A.192;

25 (c) Treatments that do not conform to acceptable and customary standards of medical practice;

26 (d) Treatments for which there is insufficient data to determine efficacy; or

27 (e) Abortion if the insurer offering the health benefit plan excluded coverage for abortion in all of its individual, small employer and large employer group plans during the 2017 plan year.

28
29 (8) If services, drugs, devices, products or procedures required by this section are provided by an out-of-network provider, the health benefit plan must cover the services, drugs, devices, products or procedures without imposing any cost-sharing requirement on the enrollee if:

30
31 (a) There is no in-network provider to furnish the service, drug, device, product or procedure that is geographically accessible or accessible in a reasonable amount of time, as defined by the Department of Consumer and Business Services by rule consistent with the requirements for provider networks in ORS 743B.505; or

32 (b) An in-network provider is unable or unwilling to provide the service in a timely manner.

33
34 (9) An insurer may offer to a religious employer a health benefit plan that does not include coverage for contraceptives or abortion procedures that are contrary to the religious employer's religious tenets only if the insurer notifies in writing all employees who may be enrolled in the health benefit plan of the contraceptives and procedures the employer refuses to cover for religious reasons.

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36
37 (10) If the Department of Consumer and Business Services concludes that enforcement of this section may adversely affect the allocation of federal funds to this state, the department may grant an exemption to the requirements but only to the minimum extent necessary to ensure the continued receipt of federal funds.

1 (11) An insurer that is subject to this section shall make readily accessible to enrollees and
2 potential enrollees, in a consumer-friendly format, information about the coverage of contraceptives
3 by each health benefit plan and the coverage of other services, drugs, devices, products and proce-
4 dures described in this section. The insurer must provide the information:

- 5 (a) On the insurer’s website; and
- 6 (b) In writing upon request by an enrollee or potential enrollee.

7 (12) This section does not prohibit an insurer from using reasonable medical management tech-
8 niques to determine the frequency, method, treatment or setting for the coverage of services, drugs,
9 devices, products and procedures described in subsection (2) of this section, other than coverage
10 required by subsection (2)(g) and (j) of this section, if the techniques:

- 11 (a) Are consistent with the coverage requirements of subsection (2) of this section; and
- 12 (b) Do not result in the wholesale or indiscriminate denial of coverage for a service.

13 **SECTION 6.** ORS 743A.168 is amended to read:

14 743A.168. (1) As used in this section:

15 (a) “Behavioral health assessment” means an evaluation by a provider, in person or using tele-
16 medicine, to determine a patient’s need for behavioral health treatment.

17 (b) “Behavioral health crisis” means a disruption in an individual’s mental or emotional stability
18 or functioning resulting in an urgent need for immediate outpatient treatment in an emergency de-
19 partment or admission to a hospital to prevent a serious deterioration in the individual’s mental or
20 physical health.

21 (c) “Chemical dependency” means the addictive relationship with any drug or alcohol charac-
22 terized by a physical or psychological relationship, or both, that interferes on a recurring basis with
23 the individual’s social, psychological or physical adjustment to common problems. For purposes of
24 this section, “chemical dependency” does not include addiction to, or dependency on, tobacco, to-
25 bacco products or foods.

26 (d) “Facility” means a corporate or governmental entity or other provider of services for the
27 treatment of chemical dependency or for the treatment of mental or nervous conditions.

28 (e) “Group health insurer” means an insurer, a health maintenance organization or a health care
29 service contractor.

30 **(f) “Prior authorization” has the meaning given that term in ORS 743B.001.**

31 [(f)] **(g)** “Program” means a particular type or level of service that is organizationally distinct
32 within a facility.

33 [(g)] **(h)** “Provider” means:

34 (A) An individual who has met the credentialing requirement of a group health insurer, is oth-
35 erwise eligible to receive reimbursement for coverage under the policy and is a behavioral health
36 professional or a medical professional licensed or certified in this state;

37 (B) A health care facility as defined in ORS 433.060;

38 (C) A residential facility as defined in ORS 430.010;

39 (D) A day or partial hospitalization program;

40 (E) An outpatient service as defined in ORS 430.010; or

41 (F) A provider organization certified by the Oregon Health Authority under subsection (7) of this
42 section.

43 **(i) “Utilization review” has the meaning given that term in ORS 743B.001.**

44 (2) A group health insurance policy providing coverage for hospital or medical expenses, other
45 than limited benefit coverage, shall provide coverage for expenses arising from the diagnosis of and

1 treatment for chemical dependency, including alcoholism, and for mental or nervous conditions at
2 the same level as, and subject to limitations no more restrictive than, those imposed on coverage
3 or reimbursement of expenses arising from treatment for other medical conditions. The following
4 apply to coverage for chemical dependency and for mental or nervous conditions:

5 (a) The coverage may be made subject to provisions of the policy that apply to other benefits
6 under the policy, including but not limited to provisions relating to deductibles and coinsurance.
7 Deductibles and coinsurance for treatment in health care facilities or residential facilities may not
8 be greater than those under the policy for expenses of hospitalization in the treatment of other
9 medical conditions. Deductibles and coinsurance for outpatient treatment may not be greater than
10 those under the policy for expenses of outpatient treatment of other medical conditions.

11 (b) The coverage may not be made subject to treatment limitations, limits on total payments for
12 treatment, limits on duration of treatment or financial requirements unless similar limitations or
13 requirements are imposed on coverage of other medical conditions. The coverage of eligible expenses
14 may be limited to treatment that is medically necessary as determined under the policy for other
15 medical conditions.

16 (c) The coverage must include:

17 (A) A behavioral health assessment;

18 (B) No less than the level of services determined to be medically necessary in a behavioral
19 health assessment of a patient or in a patient's care plan:

20 (i) To treat the patient's behavioral health condition; and

21 (ii) For care following a behavioral health crisis, to transition the patient to a lower level of
22 care; and

23 (C) Coordinated care and case management as defined by the Department of Consumer and
24 Business Services by rule.

25 (d) A provider is eligible for reimbursement under this section if:

26 (A) The provider is approved or certified by the Oregon Health Authority;

27 (B) The provider is accredited for the particular level of care for which reimbursement is being
28 requested by the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities;

29 (C) The patient is staying overnight at the facility and is involved in a structured program at
30 least eight hours per day, five days per week; or

31 (D) The provider is providing a covered benefit under the policy.

32 (e) If specified in the policy, outpatient coverage may include follow-up in-home service or out-
33 patient services. The policy may limit coverage for in-home service to persons who are homebound
34 under the care of a physician.

35 (f)(A) Subject to the patient or client confidentiality provisions of ORS 40.235 relating to physi-
36 cians, ORS 40.240 relating to nurse practitioners, ORS 40.230 relating to psychologists, ORS 40.250
37 and 675.580 relating to licensed clinical social workers and ORS 40.262 relating to licensed profes-
38 sional counselors and licensed marriage and family therapists, a group health insurer may provide
39 for review for level of treatment of admissions and continued stays for treatment in health facilities,
40 residential facilities, day or partial hospitalization programs and outpatient services by either group
41 health insurer staff or personnel under contract to the group health insurer, or by a utilization re-
42 view contractor, who shall have the authority to certify for or deny level of payment.

43 (B) Review shall be made according to criteria made available to providers in advance upon
44 request.

45 (C) Review shall be performed by or under the direction of a physician licensed under ORS

1 677.100 to 677.228, a psychologist licensed by the Oregon Board of Psychology, a clinical social
2 worker licensed by the State Board of Licensed Social Workers or a professional counselor or mar-
3 riage and family therapist licensed by the Oregon Board of Licensed Professional Counselors and
4 Therapists, in accordance with standards of the National Committee for Quality Assurance or
5 Medicare review standards of the Centers for Medicare and Medicaid Services.

6 (D) Review may involve prior approval, concurrent review of the continuation of treatment,
7 post-treatment review or any combination of these. However, if prior approval is required, provision
8 shall be made to allow for payment of urgent or emergency admissions, subject to subsequent re-
9 view. If prior approval is not required, group health insurers shall permit providers, policyholders
10 or persons acting on their behalf to make advance inquiries regarding the appropriateness of a
11 particular admission to a treatment program. Group health insurers shall provide a timely response
12 to such inquiries. Noncontracting providers must cooperate with these procedures to the same ex-
13 tent as contracting providers to be eligible for reimbursement.

14 (g) Health maintenance organizations may limit the receipt of covered services by enrollees to
15 services provided by or upon referral by providers contracting with the health maintenance organ-
16 ization. Health maintenance organizations and health care service contractors may create substan-
17 tive plan benefit and reimbursement differentials at the same level as, and subject to limitations no
18 more restrictive than, those imposed on coverage or reimbursement of expenses arising out of other
19 medical conditions and apply them to contracting and noncontracting providers.

20 (3) This section does not prohibit a group health insurer from managing the provision of benefits
21 through common methods, including but not limited to selectively contracted panels, health plan
22 benefit differential designs, preadmission screening, prior authorization of services, utilization re-
23 view or other mechanisms designed to limit eligible expenses to those described in subsection (2)(b)
24 of this section.

25 (4) The Legislative Assembly finds that health care cost containment is necessary and intends
26 to encourage health insurance plans designed to achieve cost containment by ensuring that re-
27 imbursement is limited to appropriate utilization under criteria incorporated into the insurance, ei-
28 ther directly or by reference.

29 (5) This section does not prevent a group health insurer from contracting with providers of
30 health care services to furnish services to policyholders or certificate holders according to ORS
31 743B.460 or 750.005, subject to the following conditions:

32 (a) A group health insurer is not required to contract with all providers that are eligible for
33 reimbursement under this section.

34 (b) An insurer or health care service contractor shall, subject to subsection (2) of this section,
35 pay benefits toward the covered charges of noncontracting providers of services for the treatment
36 of chemical dependency or mental or nervous conditions. The insured shall, subject to subsection
37 (2) of this section, have the right to use the services of a noncontracting provider of services for the
38 treatment of chemical dependency or mental or nervous conditions, whether or not the services for
39 chemical dependency or mental or nervous conditions are provided by contracting or noncontracting
40 providers.

41 (6)(a) This section does not require coverage for:

42 (A) Educational or correctional services or sheltered living provided by a school or halfway
43 house;

44 (B) A long-term residential mental health program that lasts longer than 45 days;

45 (C) Psychoanalysis or psychotherapy received as part of an educational or training program,

1 regardless of diagnosis or symptoms that may be present;

2 (D) A court-ordered sex offender treatment program; or

3 (E) Support groups.

4 (b) Notwithstanding paragraph (a)(A) of this subsection, an insured may receive covered outpa-
5 tient services under the terms of the insured's policy while the insured is living temporarily in a
6 sheltered living situation.

7 (7) The Oregon Health Authority shall establish a process for the certification of an organiza-
8 tion described in subsection (1)(g)(F) of this section that:

9 (a) Is not otherwise subject to licensing or certification by the authority; and

10 (b) Does not contract with the authority, a subcontractor of the authority or a community
11 mental health program.

12 (8) The Oregon Health Authority shall adopt by rule standards for the certification provided
13 under subsection (7) of this section to ensure that a certified provider organization offers a distinct
14 and specialized program for the treatment of mental or nervous conditions.

15 (9) The Oregon Health Authority may adopt by rule an application fee or a certification fee, or
16 both, to be imposed on any provider organization that applies for certification under subsection (7)
17 of this section. Any fees collected shall be paid into the Oregon Health Authority Fund established
18 in ORS 413.101 and shall be used only for carrying out the provisions of subsection (7) of this sec-
19 tion.

20 (10) The intent of the Legislative Assembly in adopting this section is to reserve benefits for
21 different types of care to encourage cost effective care and to ensure continuing access to levels
22 of care most appropriate for the insured's condition and progress. This section does not prohibit an
23 insurer from requiring a provider organization certified by the Oregon Health Authority under sub-
24 section (7) of this section to meet the insurer's credentialing requirements as a condition of entering
25 into a contract.

26 (11) The Director of the Department of Consumer and Business Services and the Oregon Health
27 Authority, after notice and hearing, may adopt reasonable rules not inconsistent with this section
28 that are considered necessary for the proper administration of this section.

29 **SECTION 7.** ORS 743A.264 is amended to read:

30 743A.264. (1) As used in this section:

31 (a) "Condition of public health importance" has the meaning given that term in ORS 431A.005.

32 (b) "Disease outbreak" has the meaning given that term in ORS 431A.005.

33 (c) "Enrollee" means an individual residing in this state who:

34 (A) Is enrolled in a health benefit plan; and

35 (B) The Public Health Director determines may be affected by a disease outbreak, epidemic or
36 other condition of public health importance.

37 (d) "Epidemic" has the meaning given that term in ORS 431A.005.

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

39 (f) "Insurer" means a person with a certificate of authority to transact insurance in this state.

40 **(g) "Utilization review" has the meaning given that term in ORS 743B.001.**

41 (2) If the director determines that there exists a disease outbreak, epidemic or other condition
42 of public health importance in a geographic area of this state or statewide, an insurer shall, for
43 enrollees in a health benefit plan offered by the insurer, cover the cost of necessary antitoxins, se-
44 rums, vaccines, immunizing agents, antibiotics, antidotes and other pharmaceutical agents, medical
45 supplies or other prophylactic measures approved by the United States Food and Drug Adminis-

1 tration that the director deems necessary to prevent the spread of the disease, epidemic or other
2 condition of public health importance.

3 (3) An insurer may not restrict coverage under subsection (2) of this section by:

4 (a) Requiring that the health services be administered by an in-network provider;

5 (b) Imposing cost-sharing requirements that are greater than the cost-sharing requirements for
6 similar covered services;

7 (c) Requiring prior authorization or other utilization [*control*] **review** measures; or

8 (d) Limiting coverage in any manner that prevents an enrollee from accessing the necessary
9 health services.

10 **SECTION 8.** ORS 743B.001 is amended to read:

11 743B.001. As used in this section and ORS 743.008, **743.029**, 743.035, **743A.190**, 743B.195,
12 743B.197, 743B.200, 743B.202, 743B.204, 743B.220, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253,
13 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.310, 743B.400, 743B.403, 743B.405, 743B.420,
14 743B.422, 743B.423, 743B.424, 743B.450, 743B.451, 743B.452, 743B.453, 743B.454, 743B.505, 743B.550
15 and 743B.555 **and section 2, chapter 771, Oregon Laws 2013:**

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

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

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

21 (c) Imposition of a preexisting condition exclusion as defined in ORS 743B.005, source-of-injury
22 exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or
23 services;

24 (d) Determination that a health care item or service is experimental, investigational or not
25 medically necessary, effective or appropriate; [*or*]

26 (e) Determination that a course or plan of treatment that an enrollee is undergoing is an active
27 course of treatment for purposes of continuity of care under ORS 743B.225; **or**

28 **(f) Denial, in whole or in part, of a request for prior authorization.**

29 (2) “Authorized representative” means an individual who by law or by the consent of a person
30 may act on behalf of the person.

31 (3) “Credit card” has the meaning given that term in 15 U.S.C. 1602.

32 (4) “Electronic funds transfer” has the meaning given that term in ORS 293.525.

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

34 (6) “Essential community provider” has the meaning given that term in rules adopted by the
35 Department of Consumer and Business Services consistent with the description of the term in 42
36 U.S.C. 18031 and the rules adopted by the United States Department of Health and Human Services,
37 the United States Department of the Treasury or the United States Department of Labor to carry
38 out 42 U.S.C. 18031.

39 (7) “Grievance” means:

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

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

44 (B) In writing or orally, for an expedited response described in ORS 743B.250 (2)(d) or an expe-
45 dited external review; or

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

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

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

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

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

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

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

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

17 (12) "Managed health insurance" means any health benefit plan that:

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

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

24 (13) "Medical services contract" means a contract between an insurer and an independent
25 practice association, between an insurer and a provider, between an independent practice associ-
26 ation and a provider or organization of providers, between medical or mental health clinics, and
27 between a medical or mental health clinic and a provider to provide medical or mental health ser-
28 vices. "Medical services contract" does not include a contract of employment or a contract creating
29 legal entities and ownership thereof that are authorized under ORS chapter 58, 60 or 70, or other
30 similar professional organizations permitted by statute.

31 (14)(a) "Preferred provider organization insurance" means any health benefit plan that:

32 (A) Specifies a preferred network of providers managed, owned or under contract with or em-
33 ployed by an insurer;

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

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

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

42 (15) "Prior authorization" means a determination by an insurer **upon request by a provider**
43 **or an enrollee**, prior to the provision of [services] **health care that is subject to utilization re-**
44 **view**, that the insurer will provide reimbursement for the [services] **health care requested**. "Prior
45 authorization" does not include referral approval for evaluation and management services between

1 providers.

2 (16)(a) "Provider" means a person licensed, certified or otherwise authorized or permitted by
3 laws of this state to administer medical or mental health services in the ordinary course of business
4 or practice of a profession.

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

8 (17) "Utilization review" means a set of formal techniques used by an insurer or delegated by
9 the insurer designed to monitor the use of or evaluate the medical necessity, appropriateness, effi-
10 cacy or efficiency of health care **items**, services, procedures or settings.

11 **SECTION 9.** ORS 743B.250 is amended to read:

12 743B.250. All insurers offering a health benefit plan in this state shall:

13 (1) Provide to all enrollees directly or in the case of a group policy to the employer or other
14 policyholder for distribution to enrollees, to all applicants, and to prospective applicants upon re-
15 quest, the following information:

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

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

18 (B) To be treated with respect and with recognition of the enrollee's dignity and need for pri-
19 vacy.

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

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

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

25 (A) The procedures for requesting an expedited response to an internal appeal under subsection
26 (2)(d) of this section or for requesting an expedited external review of an adverse benefit determi-
27 nation;

28 (B) A statement that if an insurer does not comply with the decision of an independent review
29 organization under ORS 743B.256, the enrollee may sue the insurer under ORS 743B.258;

30 (C) The procedure to obtain assistance available from the insurer, if any, and from the Depart-
31 ment of Consumer and Business Services in filing grievances; and

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

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

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

36 (A) Cost-sharing differentials;

37 (B) Restrictions on coverage;

38 (C) Prescription drug formularies;

39 (D) Procedures by which a provider with prescribing authority may prescribe clinically appro-
40 priate drugs not included on the formulary;

41 (E) Procedures for the coverage of clinically appropriate prescription drugs not included on the
42 formulary; and

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

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

1 and hospital networks. The list must be available online and upon request in printed format.

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

3 (g) How to obtain referrals for specialty care in accordance with ORS 743B.227.

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

5 (i) The availability of continuity of care as required by ORS 743B.225.

6 (j) Procedures for accessing after-hours care and emergency services as required by ORS
7 743A.012.

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

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

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

12 (n) A summary of how the insurer makes decisions regarding coverage and payment for treat-
13 ment or services, including a general description of any prior authorization and utilization [*control*]
14 **review** requirements that affect coverage or payment.

15 (o) Disclosure of any risk-sharing arrangement the insurer has with physicians or other provid-
16 ers.

17 (p) A summary of the insurer's procedures for protecting the confidentiality of medical records
18 and other enrollee information and the requirement under ORS 743B.555 that a carrier or third
19 party administrator send communications containing protected health information only to the
20 enrollee who is the subject of the protected health information.

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

22 (r) Notice of the information available from the department that is filed by insurers as required
23 under ORS 743B.200, 743B.202 and 743B.423.

24 (2) Establish procedures, in accordance with requirements adopted by the department, for mak-
25 ing coverage determinations and resolving grievances that provide for all of the following:

26 (a) Timely notice of adverse benefit determinations.

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

29 (c) Written decisions.

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

32 (e) At least one but not more than two levels of internal appeal for group health benefit plans
33 and one level of internal appeal for individual health benefit plans and for any denial of an exception
34 to a prescription drug formulary. If an insurer provides:

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

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

40 (f)(A) An external review that meets the requirements of ORS 743B.252, 743B.254 and 743B.255,
41 after the enrollee has exhausted internal appeals or after the enrollee has been deemed to have
42 exhausted internal appeals.

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

45 (g) The opportunity for the enrollee to receive continued coverage of an approved and ongoing

1 course of treatment under the health benefit plan pending the conclusion of the internal appeal
2 process.

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

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

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

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

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

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

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

12 (4) Provide the information described in subsection (2) of this section and ORS 743B.254 at each
13 level of internal appeal to an enrollee who is notified of an adverse benefit determination or to an
14 enrollee who files a grievance.

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

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

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

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

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

26 (7) Maintain for a period of at least six years written records that document all grievances de-
27 scribed in ORS 743B.001 (7)(a) and make the written records available for examination by the de-
28 partment or by an enrollee or authorized representative of an enrollee with respect to a grievance
29 made by the enrollee. The written records must include but are not limited to the following:

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

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

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

33 (d) The date of the internal appeal or the date of any internal appeal meeting held concerning
34 the appeal.

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

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

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

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

42 **SECTION 10.** ORS 746.230 is amended to read:

43 746.230. (1) [No] **An** insurer or other person [shall] **may not** commit or perform any of the fol-
44 lowing unfair claim settlement practices:

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

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

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

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

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

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

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

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

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

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

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

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

24 (m) Failing to promptly provide the proper explanation of the basis relied on in the insurance
25 policy in relation to the facts or applicable law for the denial of a claim[.]; **or**

26 **(n) Any of the practices described in section 2 of this 2019 Act.**

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

30 (a) A substantial increase in the number of complaints against the insurer received by the De-
31 partment of Consumer and Business Services;

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

34 (c) Other relevant evidence.

35 **SECTION 11.** Section 2, chapter 771, Oregon Laws 2013, as amended by section 9, chapter 674,
36 Oregon Laws 2015, is amended to read:

37 **Sec. 2.** (1) As used in this section and section 3a, chapter 771, Oregon Laws 2013:

38 (a)(A) "Applied behavior analysis" means the design, implementation and evaluation of environ-
39 mental modifications, using behavioral stimuli and consequences, to produce significant improvement
40 in human social behavior, including the use of direct observation, measurement and functional
41 analysis of the relationship between environment and behavior, that is provided by:

42 (i) A licensed health care professional as defined in [section 1 of this 2015 Act] **ORS 676.802**;

43 (ii) A behavior analyst or assistant behavior analyst licensed under [section 3 of this 2015 Act]
44 **ORS 676.810**; or

45 (iii) A behavior analysis interventionist registered under [section 4 of this 2015 Act] **ORS 676.815**

1 who receives ongoing training and supervision by a licensed behavior analyst, by a licensed assist-
2 ant behavior analyst or by a licensed health care professional.

3 (B) "Applied behavior analysis" does not mean psychological testing, neuropsychology,
4 psychotherapy, cognitive therapy, sex therapy, psychoanalysis, hypnotherapy and long-term coun-
5 seling as treatment modalities.

6 (b) "Autism spectrum disorder" has the meaning given that term in the fifth edition of the Di-
7 agnostic and Statistical Manual of Mental Disorders (DSM-5) published by the American Psychiatric
8 Association.

9 (c) "Diagnosis" means medically necessary assessment, evaluation or testing.

10 (d) "Health benefit plan" has the meaning given that term in ORS [743.730] **743B.005**.

11 (e) "Medically necessary" means in accordance with the definition of medical necessity that is
12 specified in the policy or certificate for the health benefit plan and that applies to all covered ser-
13 vices under the plan.

14 (f) "Treatment for autism spectrum disorder" includes applied behavior analysis for up to 25
15 hours per week and any other mental health or medical services identified in the individualized
16 treatment plan, as described in subsection (6) of this section.

17 (2) A health benefit plan shall provide coverage of:

18 (a) The screening for and diagnosis of autism spectrum disorder by a licensed neurologist,
19 pediatric neurologist, developmental pediatrician, psychiatrist or psychologist, who has experience
20 or training in the diagnosis of autism spectrum disorder; and

21 (b) Medically necessary treatment for autism spectrum disorder and the management of care, for
22 an individual who begins treatment before nine years of age, subject to the requirements of this
23 section.

24 (3) This section does not require coverage for:

25 (a) Services provided by a family or household member;

26 (b) Services that are custodial in nature or that constitute marital, family, educational or
27 training services;

28 (c) Custodial or respite care, equine assisted therapy, creative arts therapy, wilderness or ad-
29 venture camps, social counseling, telemedicine, music therapy, neurofeedback, chelation or
30 hyperbaric chambers;

31 (d) Services provided under an individual education plan in accordance with the Individuals with
32 Disabilities Education Act, 20 U.S.C. 1400 et seq.;

33 (e) Services provided through community or social programs; or

34 (f) Services provided by the Department of Human Services or the Oregon Health Authority,
35 other than employee benefit plans offered by the department and the authority.

36 (4) An insurer may not terminate coverage or refuse to issue or renew coverage for an individ-
37 ual solely because the individual has received a diagnosis of autism spectrum disorder or has re-
38 ceived treatment for autism spectrum disorder.

39 (5) Coverage under this section may be subject to utilization controls that are reasonable in the
40 context of individual determinations of medical necessity. An insurer may require:

41 (a) An autism spectrum disorder diagnosis by a professional described in subsection (2)(a) of this
42 section if the original diagnosis was not made by a professional described in subsection (2)(a) of this
43 section.

44 (b) Prior authorization for coverage of a maximum of 25 hours per week of applied behavior
45 analysis recommended in an individualized treatment plan approved by a professional described in

1 subsection (2)(a) of this section for an individual with autism spectrum disorder, as long as the
2 insurer makes a prior authorization determination no later than 30 calendar days after receiving the
3 request for prior authorization, **notwithstanding ORS 743B.423.**

4 (6) If an individual is receiving applied behavior analysis, an insurer may require submission of
5 an individualized treatment plan, which shall include all elements necessary for the insurer to ap-
6 propriately determine coverage under the health benefit plan. The individualized treatment plan
7 must be based on evidence-based screening criteria. An insurer may require an updated individual-
8 ized treatment plan, not more than once every six months, that includes observed progress as of the
9 date the updated plan was prepared, for the purpose of performing utilization review and medical
10 management. The insurer may require the individualized treatment plan to be approved by a pro-
11 fessional described in subsection (2)(a) of this section, and to include the:

12 (a) Diagnosis;

13 (b) Proposed treatment by type;

14 (c) Frequency and anticipated duration of treatment;

15 (d) Anticipated outcomes stated as goals, including specific cognitive, social, communicative,
16 self-care and behavioral goals that are clearly stated, directly observed and continually measured
17 and that address the characteristics of the autism spectrum disorder; and

18 (e) Signature of the treating provider.

19 (7)(a) Once coverage for applied behavior analysis has been approved, the coverage continues
20 as long as:

21 (A) The individual continues to make progress toward the majority of the goals of the individ-
22 ualized treatment plan; and

23 (B) Applied behavior analysis is medically necessary.

24 (b) An insurer may require periodic review of an individualized treatment plan, as described in
25 subsection (6) of this section, and modification of the individualized treatment plan if the review
26 shows that the individual receiving the treatment is not making substantial clinical progress toward
27 the goals of the individualized treatment plan.

28 (8) Coverage under this section may be subject to requirements and limitations no more re-
29 strictive than those imposed on coverage or reimbursement of expenses arising from the treatment
30 of other medical conditions under the policy or certificate, including but not limited to:

31 (a) Requirements and limitations regarding in-network providers; and

32 (b) Provisions relating to deductibles, copayments and coinsurance.

33 (9) This section applies to coverage for up to 25 hours per week of applied behavior analysis for
34 an individual if the coverage is first requested when the individual is under nine years of age. This
35 section does not limit coverage for any services that are otherwise available to an individual under
36 ORS 743A.168 or 743A.190, including but not limited to:

37 (a) Treatment for autism spectrum disorder other than applied behavior analysis or the services
38 described in subsection (3) of this section;

39 (b) Applied behavior analysis for more than 25 hours per week; or

40 (c) Applied behavior analysis for an individual if the coverage is first requested when the indi-
41 vidual is nine years of age or older.

42 (10) Coverage under this section includes treatment for autism spectrum disorder provided in the
43 individual's home or a licensed health care facility or, for treatment provided by a licensed health
44 care professional as defined in [section 1 of this 2015 Act] **ORS 676.802** or a behavior analyst or
45 assistant behavior analyst licensed under [section 3 of this 2015 Act] **ORS 676.810**, in a setting ap-

1 proved by the health care professional, behavior analyst or assistant behavior analyst.

2 (11) An insurer that provides coverage of applied behavior analysis in accordance with a deci-
3 sion of an independent review organization that was made prior to January 1, 2016, shall continue
4 to provide coverage, subject to modifications made in accordance with subsection (7) of this section.

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

6 **SECTION 12.** ORS 743B.001, as amended by section 8 of this 2019 Act, is amended to read:

7 743B.001. As used in this section and ORS 743.008, 743.029, 743.035, 743A.190, 743B.195,
8 743B.197, 743B.200, 743B.202, 743B.204, 743B.220, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253,
9 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.310, 743B.400, 743B.403, 743B.405, 743B.420,
10 743B.422, 743B.423, 743B.424, 743B.450, 743B.451, 743B.452, 743B.453, 743B.454, 743B.505, 743B.550
11 and 743B.555 [*and section 2, chapter 771, Oregon Laws 2013*]:

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

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

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

17 (c) Imposition of a preexisting condition exclusion as defined in ORS 743B.005, source-of-injury
18 exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or
19 services;

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

22 (e) Determination that a course or plan of treatment that an enrollee is undergoing is an active
23 course of treatment for purposes of continuity of care under ORS 743B.225; or

24 (f) Denial, in whole or in part, of a request for prior authorization.

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

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

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

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

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

35 (7) "Grievance" means:

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

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

40 (B) In writing or orally, for an expedited response described in ORS 743B.250 (2)(d) or an expe-
41 dited external review; or

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

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

45 (B) Claims payment, handling or reimbursement for health care services and, unless the enrollee

1 has not submitted a request for an internal appeal, the complaint is not disputing an adverse benefit
2 determination; or

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

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

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

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

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

13 (12) "Managed health insurance" means any health benefit plan that:

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

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

20 (13) "Medical services contract" means a contract between an insurer and an independent
21 practice association, between an insurer and a provider, between an independent practice associ-
22 ation and a provider or organization of providers, between medical or mental health clinics, and
23 between a medical or mental health clinic and a provider to provide medical or mental health ser-
24 vices. "Medical services contract" does not include a contract of employment or a contract creating
25 legal entities and ownership thereof that are authorized under ORS chapter 58, 60 or 70, or other
26 similar professional organizations permitted by statute.

27 (14)(a) "Preferred provider organization insurance" means any health benefit plan that:

28 (A) Specifies a preferred network of providers managed, owned or under contract with or em-
29 ployed by an insurer;

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

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

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

38 (15) "Prior authorization" means a determination by an insurer upon request by a provider or
39 an enrollee, prior to the provision of health care that is subject to utilization review, that the
40 insurer will provide reimbursement for the health care requested. "Prior authorization" does not
41 include referral approval for evaluation and management services between providers.

42 (16)(a) "Provider" means a person licensed, certified or otherwise authorized or permitted by
43 laws of this state to administer medical or mental health services in the ordinary course of business
44 or practice of a profession.

45 (b) With respect to the statutes governing the billing for or payment of claims, "provider" also

1 includes an employee or other designee of the provider who has the responsibility for billing claims
2 for reimbursement or receiving payments on claims.

3 (17) "Utilization review" means a set of formal techniques used by an insurer or delegated by
4 the insurer designed to monitor the use of or evaluate the medical necessity, appropriateness, effi-
5 cacy or efficiency of health care items, services, procedures or settings.

6 **SECTION 13. Section 2 of this 2019 Act and the amendments to ORS 743B.422, 743B.423**
7 **and 746.230 and section 2, chapter 771, Oregon Laws 2013, by sections 3, 4, 10 and 11 of this**
8 **2019 Act apply to policies or certificates of insurance and medical services contracts issued,**
9 **renewed, entered into or extended on or after the effective date of this 2019 Act.**

10 **SECTION 14. The amendments to ORS 743B.001 by section 12 of this 2019 Act become**
11 **operative on January 2, 2022.**

12