74th OREGON LEGISLATIVE ASSEMBLY--2007 Regular Session

House Bill 2213

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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.**

Requires insurer offering health benefit plan to disclose, upon request of enrollee, anticipated cost to enrollee of prescribed procedure or service.

Requires Director of Department of Consumer and Business Services to adopt rules specifying standards for disclosure of enrollee's share of cost for prescribed procedure or service under health benefit plan, and to establish standard method of determining usual, customary and reasonable payment to noncontracted providers.

1 **A BILL FOR AN ACT**

2 Relating to payments for procedures covered by health benefit plan; creating new provisions; and
3 amending ORS 743.801 and 743.804.

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

5 **SECTION 1.** ORS 743.804 is amended to read:

6 743.804. All insurers offering a health benefit plan in this state shall:

7 (1) Have a written policy that recognizes the rights of enrollees:

8 (a) To voice grievances about the organization or health care provided;

9 (b) To be provided with information about the organization, its services and the providers pro-
10 viding care;

11 (c) To participate in decision making regarding their health care; and

12 (d) To be treated with respect and recognition of their dignity and need for privacy.

13 (2) Provide a summary of policies on enrollees' rights and responsibilities to all participating
14 providers upon request and to all enrollees either directly or, in the case of group coverage, to the
15 employer or other policyholder for distribution to enrollees.

16 (3) Have a timely and organized system for resolving grievances and appeals. The system shall
17 include:

18 (a) A systematic method for recording all grievances and appeals, including the nature of the
19 grievances, and significant actions taken;

20 (b) Written procedures explaining the grievance and appeal process, including a procedure to
21 assist enrollees in filing written grievances;

22 (c) Written decisions in plain language justifying grievance determinations, including appropri-
23 ate references to relevant policies, procedures and contract terms;

24 (d) Standards for timeliness in responding to grievances or appeals that accommodate the clin-
25 ical urgency of the situation;

26 (e) Notice in all written decisions prepared pursuant to this subsection that the enrollee may file
27 a complaint with the Director of the Department of Consumer and Business Services; and

28 (f) An appeal process for grievances that includes at least the following:

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.

(A) Three levels of review, the second of which shall be by persons not previously involved in the dispute and the third of which shall provide external review pursuant to an external review program meeting the requirements of ORS 743.857, 743.859 and 743.861;

(B) Opportunity for enrollees and any representatives of the enrollees to appear before a review panel at either the first or second level of review. Representatives may include health care providers or any other persons chosen by the enrollee. The enrollee and insurer shall each provide advance notification of the number of representatives who will appear before the panel and the relationship of the representatives to the enrollee or insurer; and

(C) Written decisions in plain language justifying appeal determinations, including specific references to relevant provisions of the health benefit plan and related written corporate practices.

(4) If the insurer has a prescription drug formulary, have:

(a) A written procedure by which a provider with authority to prescribe drugs and medications may prescribe drugs and medications not included in the formulary. The procedure shall include the circumstances when a drug or medication not included in the formulary will be considered a covered benefit; and

(b) A written procedure to provide full disclosure to enrollees of any cost sharing or other requirements to obtain drugs and medications not included in the formulary.

(5) Furnish to all enrollees either directly or, in the case of a group policy, to the employer or other policyholder for distribution to enrollees written general information informing enrollees about services provided, access to services, charges and scheduling applicable to each enrollee's coverage, including:

(a) Benefits and services included and how to obtain them, including any restrictions that apply to services obtained outside the insurer's network or outside the insurer's service area, and the availability of continuity of care as required by ORS 743.854;

(b) Provisions for referrals, if any, for specialty care, behavioral health services and hospital services and how enrollees may obtain the care or services;

(c) Provisions for after-hours and emergency care and how enrollees may obtain that care, including the insurer's policy, if any, on when enrollees should directly access emergency care and use 9-1-1 services;

(d) Charges to enrollees, if applicable, including any policy on cost sharing for which the enrollee is responsible;

(e) Procedures for notifying enrollees of:

(A) A change in or termination of any benefit;

(B) If applicable, termination of a primary care delivery office or site; and

(C) If applicable, assistance available to enrollees affected by the termination of a primary care delivery office or site in selecting a new primary care delivery office or site;

(f) Procedures for appealing decisions adversely affecting the enrollee's benefits or enrollment status;

(g) Procedures, if any, for changing providers;

(h) Procedures for voicing grievances, including the option of obtaining external review under the insurer's program established pursuant to ORS 743.857, 743.859 and 743.861;

(i) A description of the procedures, if any, by which enrollees and their representatives may participate in the development of the insurer's corporate policies and practices;

(j) Summary information on how the insurer makes decisions regarding coverage and payment for treatment or services, including a general description of any prior authorization and utilization

review requirements that affect coverage or payment;

(k) A summary of criteria used to determine if a service or drug is considered experimental or investigational;

(L) Information about provider, clinic and hospital networks, if any, including a list of network providers and information about how the enrollee may obtain current information about the availability of individual providers, the hours the providers are available and a description of any limitations on the ability of enrollees to select primary and specialty care providers;

(m) A general disclosure of any risk-sharing arrangements the insurer has with physicians and other providers;

(n) A summary of the insurer's procedures for protecting the confidentiality of medical records and other enrollee information;

(o) A description of any assistance provided to non-English-speaking enrollees;

(p) A summary of the insurer's policies, if any, on drug prescriptions, including any drug formularies, cost sharing differentials or other restrictions that affect coverage of drug prescriptions;

(q) Notice of the enrollee's right to file a complaint or seek other assistance from the Director of the Department of Consumer and Business Services; and

(r) Notice of the information that is available upon request pursuant to subsection (6) of this section and information that is available from the Department of Consumer and Business Services pursuant to ORS 743.804, 743.807, 743.814 and 743.817.

(6) Provide the following information upon the request of an enrollee or prospective enrollee:

(a) Rules related to the insurer's drug formulary, if any, including information on whether a particular drug is included or excluded from the formulary;

(b) Provisions for referrals, if any, for specialty care, behavioral health services and hospital services and how enrollees may obtain the care or services;

(c) A copy of the insurer's annual report on grievances and appeals as submitted to the department under subsection (9) of this section;

(d) A description of the insurer's risk-sharing arrangements with physicians and other providers consistent with risk-sharing information required by the federal Health Care Financing Administration pursuant to 42 C.F.R. 417.124 (3)(b) as in effect on June 18, 1997;

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

(f) Information about any insurer procedures for credentialing network providers and how to obtain the names, qualifications and titles of the providers responsible for an enrollee's care; and

(g) A description of the insurer's external review program established pursuant to ORS 743.857, 743.859 and 743.861.

(7) Except as otherwise provided in this subsection, provide to enrollees, upon request, 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 section shall require an insurer to advise an enrollee how the insurer would cover or treat that particular enrollee's disease or condition. Utilization review criteria that is proprietary shall be subject to verbal disclosure only.

(8) Provide the following information to an enrollee when the enrollee has filed a grievance:

(a) Detailed information on the insurer's grievance and appeal procedures and how to use them;

(b) Information on how to access the complaint line of the Department of Consumer and Busi-

1 ness Services; and
2 (c) Information explaining how an enrollee applies for external review of the insurer's actions
3 under the external review program established by the insurer pursuant to ORS 743.857.
4 (9) Provide annual summaries to the Department of Consumer and Business Services of the
5 insurer's aggregate data regarding grievances, appeals and applications for external review in a
6 format prescribed by the department to ensure consistent reporting on the number, nature and dis-
7 position of grievances, appeals and applications for external review.
8 (10) Ensure that the confidentiality of specified patient information and records is protected, and
9 to that end:
10 (a) Adopt and implement written confidentiality policies and procedures;
11 (b) State the insurer's expectations about the confidentiality of enrollee information and records
12 in medical service contracts; and
13 (c) Afford enrollees the opportunity to approve or deny the release of identifiable medical per-
14 sonal information by the insurer, except as otherwise permitted or required by law.
15 (11) Notify an enrollee of the enrollee's rights under the health benefit plan at the time that the
16 insurer notifies the enrollee of an adverse decision. The notification shall include:
17 (a) Notice of the right of the enrollee to apply for internal and external review of the adverse
18 decision;
19 (b) A statement whether a decision by an independent review organization is binding on the
20 insurer and enrollee;
21 (c) A statement that if the decision is not binding on the insurer and if the insurer does not
22 comply with the decision, the enrollee may sue the insurer as provided in ORS 743.864; and
23 (d) Information on filing a complaint with the Director of the Department of Consumer and
24 Business Services.
25 **(12)(a) Establish a procedure for disclosing to an enrollee, with respect to specified pro-**
26 **cedures or services prescribed for the enrollee and covered by the plan, the cost of the pro-**
27 **cedure or service for which the enrollee will be responsible through deductibles, coinsurance**
28 **or another cost sharing method used by the insurer. The insurer must disclose, upon the**
29 **enrollee's request and in advance of the procedure or service, the actual cost to be borne**
30 **by the enrollee, if available, or a reasonable estimate of the cost.**
31 **(b) The director by rule shall specify the procedures and services to which this subsection**
32 **applies and standards for the disclosure required under this subsection.**
33 **SECTION 2. Section 3 of this 2007 Act is added to and made a part of ORS chapter 743.**
34 **SECTION 3. (1) The Director of the Department of Consumer and Business Services by**
35 **rule shall establish a standard method to be used by insurers to determine the usual, cus-**
36 **tomary and reasonable amounts to be reimbursed for procedures and services covered under**
37 **a health benefit plan when the insurer does not have a pricing agreement with a provider for**
38 **procedures or services performed by the provider for an enrollee.**
39 **(2) An insurer of a health benefit plan shall use the standard method established under**
40 **subsection (1) of this section to calculate the amount of reimbursement to be paid by the**
41 **insurer for a covered procedure or service provided by a provider with whom the insurer**
42 **does not have a pricing agreement for services covered under the plan.**
43 **SECTION 4.** ORS 743.801 is amended to read:
44 743.801. As used in ORS 743.699, 743.801, 743.803, 743.804, 743.806, 743.807, 743.808, 743.811,
45 743.814, 743.817, 743.819, 743.821, 743.823, 743.827, 743.829, 743.831, 743.834, 743.837, 743.839, 743.854,

743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.866 and 743.868 **and section 3 of this 2007 Act**:

(1) "Emergency medical condition" means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus in the case of a pregnant woman, in serious jeopardy.

(2) "Emergency medical screening exam" means the medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an emergency medical condition.

(3) "Emergency services" means those health care items and services furnished in an emergency department and all ancillary services routinely available to an emergency department to the extent they are required for the stabilization of a patient.

(4) "Enrollee" has the meaning given that term in ORS 743.730.

(5) "Grievance" means a written complaint submitted by or on behalf of an enrollee regarding the:

(a) Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(b) Claims payment, handling or reimbursement for health care services; or

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

(6) "Health benefit plan" has the meaning provided for that term in ORS 743.730.

(7) "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 743.522, to provide health care services to group members.

(8) "Insurer" has the meaning provided for that term in ORS 731.106. For purposes of ORS 743.699, 743.801, 743.803, 743.804, 743.806, 743.807, 743.808, 743.811, 743.814, 743.817, 743.819, 743.821, 743.823, 743.827, 743.829, 743.831, 743.834, 743.837, 743.839, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.866, 743.868, 750.055 and 750.333 **and section 3 of this 2007 Act**, "insurer" also includes a health care service contractor as defined in ORS 750.005.

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

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

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

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

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

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

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

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

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

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

(13) "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.

(14) "Stabilization" means that, within reasonable medical probability, no material deterioration of an emergency medical condition is likely to occur.

(15) "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 5. Section 3 of this 2007 Act and the amendments to ORS 743.801 and 743.804 by sections 1 and 4 of this 2007 Act apply to health insurance policies or certificates issued or renewed on or after the effective date of this 2007 Act.