A-Engrossed
Senate Bill 153

Ordered by the Senate May 9
Including Senate Amendments dated May 9

Printed pursuant to Senate Interim Rule 213.28 by order of the President of the Senate in conformance with presession filing rules, indicating neither advocacy nor opposition on the part of the President (at the request of Governor Theodore R. Kulongoski for Department of Human 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.

Requires employee benefit plan and health insurer to reimburse state Medicaid expenditures made for benefit of enrollee under specified circumstances. Requires employee benefit plan and health insurer to provide eligibility and claims data to state Medicaid agency upon request.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to health insurers; creating new provisions; amending ORS 659.830 and 743.847; and declaring an emergency.

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

SECTION 1. ORS 659.830 is amended to read:

659.830. (1) [*No*] **An** employee benefit plan may **not** include any provision which has the effect of limiting or excluding coverage or payment for any health care for an individual who would otherwise be covered or entitled to benefits or services under the terms of the employee benefit plan because that individual is provided, or is eligible for, benefits or services pursuant to a plan under Title XIX of the Social Security Act. This section applies to employee benefit plans, whether sponsored by an employer or a labor union.

(2) A group health plan is prohibited from considering the availability or eligibility for medical assistance in this or any other state under 42 U.S.C. 1396a (section 1902 of the Social Security Act), herein referred to as Medicaid, when considering eligibility for coverage or making payments under its plan for eligible enrollees, subscribers, policyholders or certificate holders.

(3) To the extent that payment for covered expenses has been made under the state Medicaid program for health care items or services furnished to an individual, in any case where a third party has a legal liability to make payments, the state is considered to have acquired the rights of the individual to payment by any other party for those health care items or services.

(4) An employee benefit plan, self-insured plan, managed care organization or group health plan, a third party administrator, fiscal intermediary or pharmacy benefit manager of the plan or organization, or other party that is, by statute, contract or agreement legally responsible for payment of a claim for a health care item or service, may not deny a claim submitted by the state Medicaid agency under subsection (3) of this section based on the date of submission of the claim, the type or format of the claim form or a failure to present proper documentation at the point of sale that is the basis of the claim if:

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) The claim is submitted by the agency within the three-year period beginning on the date on which the health care item or service was furnished; and

(b) Any action by the agency to enforce its rights with respect to the claim is commenced within six years of the agency's submission of the claim.

(5) An employee benefit plan, self-insured plan, managed care organization or group health plan, a third party administrator, fiscal intermediary or pharmacy benefit manager of the plan or organization, or other party that is, by statute, contract or agreement legally responsible for payment of a claim for a health care item or service, must provide to the state Medicaid agency or prepaid managed care health services organization described in ORS 414.725, upon the request of the agency or contractor, the following information:

(a) The period during which a Medicaid recipient, the spouse or dependents may be or may have been covered by the plan or organization;

(b) The nature of coverage that is or was provided by the plan or organization; and

(c) The name, address and identifying numbers of the plan or organization.

[*(4)*] **(6)** A group health plan [*shall*] **may** not deny enrollment of a child under the health plan of the child's parent on the grounds that:

(a) The child was born out of wedlock;

(b) The child is not claimed as a dependent on the parent's federal tax return; or

(c) The child does not reside with the child's parent or in the group health plan service area.

[*(5)*] **(7)** Where a child has health coverage through a group health plan of a noncustodial parent, the group health plan [*shall*] **must**:

(a) Provide such information to the custodial parent as may be necessary for the child to obtain benefits through that coverage;

(b) Permit the custodial parent or the provider, with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent; and

[*(c) Make payments on claims submitted in accordance with paragraph (b) of this subsection directly to the custodial parent, the provider or the state Medicaid agency.*]

(c) Make payments on claims submitted in accordance with paragraph (b) of this subsection directly to the custodial parent, to the provider or, if a claim is filed by the state Medicaid agency, directly to the state Medicaid agency.

[*(6)*] **(8)** Where a parent is required by a court or administrative order to provide health coverage for a child, and the parent is eligible for family health coverage, the group health plan [*shall be*] **is** required:

(a) To permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions;

(b) If the parent is enrolled but fails to make application to obtain coverage for the child, to enroll the child under family coverage upon application of the child's other parent, the state agency administering the Medicaid program or the state agency administering 42 U.S.C. 651 to 669, the child support enforcement program; and

(c) Not to disenroll or eliminate coverage of the child unless the group health plan is provided satisfactory written evidence that:

(A) The court or administrative order is no longer in effect; or

(B) The child is or will be enrolled in comparable health coverage through another insurer which will take effect not later than the effective date of disenrollment.

[*(7)*] **(9)** A group health plan may not impose requirements on a state agency[*, which*] **that** has

been assigned the rights of an individual eligible for medical assistance under Medicaid and covered for health benefits from [*such*] **the** plan[*, that*] **if the requirements** are different from requirements applicable to an agent or assignee of any other individual so covered.

[*(8)(a)*] **(10)(a)** In any case in which a group health plan provides coverage for dependent children of participants or beneficiaries, the plan [*shall*] **must** provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply to the natural, dependent children of the participants and beneficiaries, regardless of whether the adoption has become final.

(b) A group health plan may not restrict coverage under the plan of any dependent child adopted by a participant or beneficiary, or placed with a participant or beneficiary for adoption, solely on the basis of a preexisting condition of the child at the time that the child would otherwise become eligible for coverage under the plan if the adoption or placement for adoption occurs while the participant or beneficiary is eligible for coverage under the plan.

[*(9)*] **(11)** As used in this section:

(a) "Child" means, in connection with any adoption, or placement for adoption of the child, an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption.

(b) "Group health plan" means a group health plan as defined in 29 U.S.C. 1167.

(c) "Placement for adoption" means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with a person terminates upon the termination of such legal obligations.

SECTION 2. ORS 743.847 is amended to read:

743.847. (1) For the purposes of this section:

(a) "Health insurer" or "insurer" means [*the issuer of any individual, franchise, group or blanket health policy or certificate or of any stop-loss or excess insurance issued in relation to a plan of a self-insured employer.*] **an employee benefit plan, self-insured plan, managed care organization or group health plan, a third party administrator, fiscal intermediary or pharmacy benefit manager of the plan or organization, or other party that is by statute, contract or agreement legally responsible for payment of a claim for a health care item or service.**

(b) "Medicaid" means medical assistance provided under 42 U.S.C. 1396a (section 1902 of the Social Security Act).

(2) A health insurer is prohibited from considering the availability or eligibility for medical assistance in this or any other state under Medicaid[,] when considering eligibility for coverage or making payments under its group or individual plan for eligible enrollees, subscribers, policyholders or certificate holders.

(3) To the extent that payment for covered expenses has been made under the state Medicaid program for health care items or services furnished to an individual, in any case when a third party has a legal liability to make payments, the state is considered to have acquired the rights of the individual to payment by any other party for those health care items or services.

(4) An insurer may not deny a claim submitted by the state Medicaid agency, or a prepaid managed care health services organization described in ORS 414.725, under subsection (3) of this section based on the date of submission of the claim, the type or format of the claim form or a failure to present proper documentation at the point of sale that is the basis of the claim if:

(a) The claim is submitted by the agency within the three-year period beginning on the

date on which the health care item or service was furnished; and

(b) Any action by the agency to enforce its rights with respect to the claim is commenced within six years of the agency's submission of the claim.

(5) An insurer must provide to the state Medicaid agency or a prepaid managed care health services organization, upon request, the following information:

(a) The period during which a Medicaid recipient, the spouse or dependents may be or may have been covered by the plan;

(b) The nature of coverage that is or was provided by the plan; and

(c) The name, address and identifying numbers of the plan.

[*(4)*] **(6)** An insurer [*shall*] **may** not deny enrollment of a child under the group or individual health plan of the child's parent on the ground that:

(a) The child was born out of wedlock;

(b) The child is not claimed as a dependent on the parent's federal tax return; or

(c) The child does not reside with the child's parent or in the insurer's service area.

[*(5)*] **(7)** When a child has group or individual health coverage through an insurer of a noncustodial parent, the insurer [*shall*] **must**:

(a) Provide such information to the custodial parent as may be necessary for the child to obtain benefits through that coverage;

(b) Permit the custodial parent or the provider, with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent; and

(c) Make payments on claims submitted in accordance with **paragraph (b) of this** subsection [*(6) of this section*] directly to the custodial parent, the provider or [*the state Medicaid agency.*]**, if a claim is filed by the state Medicaid agency or a prepaid managed health care services organization, directly to the agency or the organization.**

[*(6)*] **(8)** When a parent is required by a court or administrative order to provide health coverage for a child, and the parent is eligible for family health coverage, the insurer [*shall*] **must**:

(a) Permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions;

(b) If the parent is enrolled but fails to make application to obtain coverage for the child, enroll the child under family coverage upon application of the child's other parent, the state agency administering the Medicaid program or the state agency administering 42 U.S.C. 651 to 669, the child support enforcement program; and

(c) Not disenroll or eliminate coverage of the child unless the insurer is provided satisfactory written evidence that:

(A) The court or administrative order is no longer in effect; or

(B) The child is or will be enrolled in comparable health coverage through another insurer which will take effect not later than the effective date of disenrollment.

[*(7)*] **(9)** An insurer may not impose requirements on a state agency that has been assigned the rights of an individual eligible for medical assistance under Medicaid and covered for health benefits from the insurer if the requirements are different from requirements applicable to an agent or assignee of any other individual so covered.

[*(8)*] **(10)** The provisions of ORS 743.700 do not apply to this section.

SECTION 3. The amendments to ORS 659.830 and 743.847 by sections 1 and 2 of this 2007 Act apply to claims submitted by the state Medicaid agency or a prepaid managed care health services organization described in ORS 414.725 and to requests for information made by the

agency or organization on or after the effective date of this 2007 Act.

SECTION 4. This 2007 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2007 Act takes effect on its passage.