A-Engrossed
Senate Bill 860

Ordered by the Senate June 17
Including Senate Amendments dated June 17

Sponsored by COMMITTEE ON HEALTH CARE, HUMAN SERVICES AND RURAL HEALTH POLICY (at the request of Oregon Health Authority)

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 Oregon Health Authority to establish payment standards for hospital, ambulatory surgical center and certain health care professional services. Requires hospitals, ambulatory surgical centers and health care professionals to bill and accept as payment in full, in specified circumstances, payments made in accordance with uniform standards prescribed by authority. Applies to payments for services provided on or after January 1, 2013.*]

[*Requires insurer to defend claim of malpractice if claim is based on disclosure of adverse event by health practitioner to patient or patient's family. Applies to insurance policies issued or renewed on or after effective date of Act. Expands coverage of immunity from liability based on expression of regret or apology to include health care institution or facility and explanation of cause of adverse event.*]

[*Expands list of health professional regulatory boards subject to health care workforce data reporting to Office for Oregon Health Policy and Research.*]

[*Authorizes Department of Consumer and Business Services to adopt uniform standards for health care financial and administrative transactions of specified persons. Authorizes Oregon Health Authority to convene stakeholder work group to recommend standards for health care financial and administrative transactions and to report recommendations to department.*]

Requires health benefit plan that provides coverage for prescription eye drops to provide coverage for one early refill for eye drops to treat glaucoma under certain circumstances.

Specifies time period for health insurer to request refund of claim paid to provider. Specifies time period for health care provider to request additional payment or to resubmit claim denied by or refunded to different insurer.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to health care; creating new provisions; amending ORS 743.912, 743.917, 750.055 and 750.333; and declaring an emergency.

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

SECTION 1. Section 2 of this 2011 Act is added to and made a part of the Insurance Code.

SECTION 2. An insurer offering a health benefit plan, as defined in ORS 743.730, that provides coverage of prescription eye drops shall provide coverage for one early refill of a prescription for eye drops to treat glaucoma if all of the following criteria are met:

(1) The refill is requested by an insured less than 30 days after the later of:

(a) The date the original prescription was dispensed to the insured; or

(b) The date that the last refill of the prescription was dispensed to the insured.

(2) The prescriber indicates on the original prescription that a specific number of refills will be needed.

(3) The refill does not exceed the number of refills that the prescriber indicated under subsection (2) of this section.

(4) The prescription has not been refilled more than once during the 30-day period prior

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.

to the request for an early refill.

SECTION 3. ORS 743.912 is amended to read:

743.912. (1) As used in this section, "refund" means the return, either directly or through an offset to a future claim, of some or all of a payment already received by a health care provider.

(2) Except in the case of fraud or abuse of billing, and except as provided in subsections (3) and (5) of this section, a health insurer may not:

(a) Request from a health care provider a refund of a payment previously made to satisfy a claim unless the health insurer:

(A) Requests the refund in writing [*within 24 months*] **on or before the last day of the period specified by the contract with the health care provider or 18 months** after the date the payment was made**, whichever is earlier**; and

(B) Specifies in the written request why the health insurer believes the provider owes the refund.

(b) Request that a contested refund be paid earlier than six months after the health care provider receives the request.

(3) A health insurer may not do the following for reasons related to coordination of benefits with another health insurer or entity responsible for payment of a claim:

(a) Request from a health care provider a refund of a payment previously made to satisfy a claim unless the health insurer:

(A) Requests the refund in writing within 30 months after the date the payment was made;

(B) Specifies in the written request why the health insurer believes the provider owes the refund; and

(C) Includes in the written request the name and mailing address of the other health insurer or entity that has primary responsibility for payment of the claim.

(b) Request that a contested refund be paid earlier than six months after the provider receives the request.

(4) If a health care provider fails to contest a refund request in writing to the health insurer within 30 days after receiving the request, the request is deemed accepted and the provider must pay the refund within 30 days after the request is deemed accepted. If the provider has not paid the refund within 30 days after the request is deemed accepted, the health insurer may recover the amount through an offset to a future claim.

(5) A health insurer may at any time request from a health care provider a refund of a payment previously made to satisfy a claim if:

(a) A third party, including a government entity, is found responsible for satisfaction of the claim as a consequence of liability imposed by law; and

(b) The health insurer is unable to recover directly from the third party because the third party has already paid or will pay the provider for the health care services covered by the claim.

(6) If a contract between a health insurer and a health care provider conflicts with this section, the provisions of this section prevail. However, nothing in this section prohibits a health care provider from choosing at any time to refund to a health insurer any payment previously made to satisfy a claim.

(7) This section neither permits nor precludes a health insurer from recovering from a subscriber, enrollee or beneficiary any amounts paid to a health care provider for benefits to which the subscriber, enrollee or beneficiary was not entitled under the terms and conditions of the health plan, insurance policy or other benefit agreement.

(8) This section [*does not apply to claims for health care services provided through dental-only health insurers, through Medicare or through Medicare supplemental plans*] **applies to health benefit plans**.

SECTION 4. ORS 743.917 is amended to read:

743.917. (1) Except in the case of fraud and except as provided in subsection [*(2)*] **(3)** of this section, a health care provider may not:

(a) Request additional payment from a health insurer to satisfy a claim unless the provider:

(A) Requests the additional payment in writing [*within 24 months*] **on or before the last day of the period specified by the contract or 18 months** after the date the claim was denied or payment intended to satisfy the claim was made**, whichever is earlier**; and

(B) Specifies in the written request why the provider believes the health insurer owes the additional payment.

(b) Request that an additional payment be paid earlier than six months after the health insurer receives the request.

(2) A health insurer may not consider a health care provider's claim untimely if the claim is made no later than 12 months after a different insurer:

(a) Denied the claim in whole or in part; or

(b) Requested a refund of an erroneous payment made on the claim.

[*(2)*] **(3)** A health care provider may not do the following for reasons related to coordination of benefits with another health insurer or entity responsible for payment of a claim:

(a) Request additional payment from a health insurer to satisfy a claim unless the provider:

(A) Requests the additional payment in writing within 30 months after the date the claim was denied or payment intended to satisfy the claim was made;

(B) Specifies in the written request why the provider believes the health insurer owes the additional payment; and

(C) Includes in the written request the name and mailing address of the other health insurer or entity that has disclaimed responsibility for payment of the claim.

(b) Request that the additional payment be paid earlier than six months after the health insurer receives the request.

[*(3)*] **(4)** If a contract between a health insurer and a health care provider conflicts with this section, the provisions of this section prevail. However, nothing in this section prohibits a health insurer from choosing at any time to make additional payments to a health care provider to satisfy a claim.

[*(4)*] **(5)** This section [*does not apply to claims for health care services provided through dental-only health insurers, through Medicare or through Medicare supplemental plans*] **applies to health benefit plans**.

SECTION 5. ORS 750.055 is amended to read:

750.055. (1) The following provisions of the Insurance Code apply to health care service contractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:

(a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.844 to 731.992 and 731.870.

(b) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.592, not including ORS 732.582.

(c) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

(d) ORS chapter 734.

(e) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to 742.540, 743.010, 743.013, 743.018 to 743.030, 743.050, 743.100 to 743.109, 743.402, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.527, 743.528, 743.529, 743.549 to 743.552, 743.560, 743.600 to 743.610, 743.650 to 743.656, 743.804, 743.807, 743.808, 743.814 to 743.839, 743.842, 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.911, 743.912, 743.913, 743.917, 743A.010, 743A.012, 743A.020, 743A.036, 743A.048, 743A.058, 743A.062, 743A.064, 743A.066, 743A.068, 743A.070, 743A.080, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144, 743A.148, 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.188, 743A.190 and 743A.192 **and section 2 of this 2011 Act**.

(f) The provisions of ORS chapter 744 relating to the regulation of insurance producers.

(g) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

(h) ORS 743A.024, except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act unless the patient is referred by a physician associated with a group practice health maintenance organization.

(i) ORS 735.600 to 735.650.

(j) ORS 743.680 to 743.689.

(k) ORS 744.700 to 744.740.

(L) ORS 743.730 to 743.773.

(m) ORS 731.485, except in the case of a group practice health maintenance organization that is federally qualified pursuant to Title XIII of the Public Health Service Act and that wholly owns and operates an in-house drug outlet.

(2) For the purposes of this section, health care service contractors shall be deemed insurers.

(3) Any for-profit health care service contractor organized under the laws of any other state that is not governed by the insurance laws of the other state is subject to all requirements of ORS chapter 732.

(4) The Director of the Department of Consumer and Business Services may, after notice and hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025 and 750.045 that are deemed necessary for the proper administration of these provisions.

SECTION 6. ORS 750.333 is amended to read:

750.333. (1) The following provisions of the Insurance Code apply to trusts carrying out a multiple employer welfare arrangement:

(a) ORS 731.004 to 731.150, 731.162, 731.216 to 731.268, 731.296 to 731.316, 731.324, 731.328, 731.378, 731.386, 731.390, 731.398, 731.406, 731.410, 731.414, 731.418 to 731.434, 731.454, 731.484, 731.486, 731.488, 731.512, 731.574 to 731.620, 731.640 to 731.652 and 731.804 to 731.992.

(b) ORS 733.010 to 733.050, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

(c) ORS chapter 734.

(d) ORS 742.001 to 742.009, 742.013, 742.061 and 742.400.

(e) ORS 743.028, 743.053, 743.524, 743.526, 743.527, 743.528, 743.529, 743.530, 743.560, 743.562, 743.600, 743.601, 743.602, 743.610, 743.730 to 743.773 (except 743.760 to 743.773), 743.801, 743.804, 743.807, 743.808, 743.814 to 743.839, 743.842, 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.912, 743.917, 743A.012, 743A.020, 743A.052, 743A.064,

743A.080, 743A.100, 743A.104, 743A.110, 743A.144, 743A.170, 743A.175, 743A.184 and 743A.192 **and section 2 of this 2011 Act**.

(f) ORS 743A.010, 743A.014, 743A.024, 743A.028, 743A.032, 743A.036, 743A.040, 743A.048, 743A.058, 743A.066, 743A.068, 743A.070, 743A.084, 743A.088, 743A.090, 743A.105, 743A.140, 743A.141, 743A.148, 743A.168, 743A.180, 743A.188 and 743A.190. Multiple employer welfare arrangements to which ORS 743.730 to 743.773 apply are subject to the sections referred to in this paragraph only as provided in ORS 743.730 to 743.773.

(g) Provisions of ORS chapter 744 relating to the regulation of insurance producers and insurance consultants, and ORS 744.700 to 744.740.

(h) ORS 746.005 to 746.140, 746.160 and 746.220 to 746.370.

(i) ORS 731.592 and 731.594.

(j) ORS 731.870.

(2) For the purposes of this section:

(a) A trust carrying out a multiple employer welfare arrangement shall be considered an insurer.

(b) References to certificates of authority shall be considered references to certificates of multiple employer welfare arrangement.

(c) Contributions shall be considered premiums.

(3) The provision of health benefits under ORS 750.301 to 750.341 shall be considered to be the transaction of health insurance.

SECTION 7. (1) Section 2 of this 2011 Act and the amendments to ORS 750.055 and 750.333 by sections 5 and 6 of this 2011 Act apply to contracts entered into or renewed, and policies or certificates issued or renewed, on or after the effective date of this 2011 Act.

(2) The amendments to ORS 743.912 and 743.917 by sections 3 and 4 of this 2011 Act apply to contracts between health insurers and health care providers that are in effect on or after the effective date of this 2011 Act.

SECTION 8. This 2011 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2011 Act takes effect on its passage.