A-Engrossed
Senate Bill 1504

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

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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.

Exempts insurer from requirement to send notice of cancellation of health benefit plan if cancellation is due to nonpayment of premium.

For group health insurance plans, requires notice to spouse of continuation coverage only if plan has 20 or more certificate holders or employer has 20 or more employees.

Delegates to Director of Department of Consumer and Business Services authority to prescribe information required to be included in notice triggered by qualifying event.

Prohibits individual health benefit plan from imposing annual limits on essential health benefits.

Modifies definition of "grievance" for purposes of filing grievance.

Requires insurer to establish procedures for enrollee to continue ongoing course of treatment pending appeal of adverse benefit determination.

Requires opportunity for review if patient is denied request for treatment on basis of lack of medical necessity.

Makes changes operative retroactive to June 23, 2011.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to health insurance; creating new provisions; amending ORS 743.499, 743.601, 743.610, 743.766, 743.801, 743.804, 743.806 and 743.822; and declaring an emergency.

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

SECTION 1. ORS 743.499 is amended to read:

743.499. (1) As used in this section, "health benefit plan" has the meaning given that term in ORS 743.730.

(2) An insurer shall notify a policyholder in writing if the insurer cancels or does not renew the policyholder's individual health benefit plan. The notice shall be sent to the policyholder's last-known mailing address by first class mail in a specially marked envelope or, if the policyholder has elected to receive communications from the insurer electronically, to the policyholder's last-known electronic mail address using a mechanism that will confirm delivery to the address.

(3) If the cancellation or nonrenewal results in a refund to the policyholder of all or part of a premium, the insurer must mail with the refund a written explanation that includes:

(a) The effective date of the cancellation;

(b) The reason for the cancellation; and

(c) The time period to which the refund is applicable.

(4) For any cancellation or nonrenewal due to a reported death of the policyholder, the insurer must:

(a) Confirm the accuracy of the reported death.

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.

(b) If the death is confirmed:

(A) Provide any dependents covered by the plan with information about how to continue coverage or obtain alternative coverage; and

(B) Issue any refund that is due to the estate of the deceased in accordance with subsection (3) of this section.

(5) If an insurer cancels or does not renew an individual health benefit plan and fails to comply with the requirements of this section, the insurer shall continue the coverage under the plan for the policyholder and any dependents covered by the plan until the date that the insurer has complied with the requirements of this section. The insurer shall waive any premiums owed for the period during which the coverage was continued under this subsection and shall process all claims incurred by the policyholder or any covered dependents according to the terms of the plan.

(6) This section does not apply:

(a) To a cancellation requested by the policyholder if the insurer documents the request and confirms the request with the policyholder; [*or*]

(b) To a cancellation or nonrenewal that results from a policyholder making a change in coverage with the same insurer**; or**

(c) To a cancellation due to nonpayment of premium.

SECTION 2. ORS 743.601 is amended to read:

743.601. (1) As used in subsections (1) to (6) of this section, "plan administrator" means:

(a) The person designated as the plan administrator by the instrument under which the group health insurance plan is operated; or

(b) If no plan administrator is designated, the plan sponsor.

(2) Within 60 days of legal separation or the entry of a judgment of dissolution of marriage, a legally separated or divorced spouse eligible for continued coverage under ORS 743.600 who seeks such coverage shall give the plan administrator written notice of the legal separation or dissolution. The notice shall include the mailing address of the legally separated or divorced spouse.

(3) Within 30 days of the death of a covered person whose surviving spouse is eligible for continued coverage under ORS 743.600, the group policyholder shall give the plan administrator written notice of the death and of the mailing address of the surviving spouse.

(4) Within 14 days of receipt of notice under subsection (2) or (3) of this section, the plan administrator shall notify the legally separated, divorced or surviving spouse that the policy may be continued. The notice shall be mailed to the mailing address provided to the plan administrator and shall include:

(a) A form for election to continue the coverage;

(b) A statement of the amount of periodic premiums to be charged for the continuation of coverage and of the method and place of payment; and

(c) Instructions for returning the election form by mail within 60 days after the date of mailing of the notice by the plan administrator.

(5) Failure of the legally separated, divorced or surviving spouse to exercise the election in accordance with subsection (4) of this section shall terminate the right to continuation of benefits.

(6) If a plan administrator fails to notify the legally separated, divorced or surviving spouse as required by subsection (4) of this section, premiums shall be waived from the date the notice was required until the date notice is received by the legally separated, divorced or surviving spouse.

(7) The provisions of this section and ORS 743.600 and 743.602 apply only to employers with 20 or more employees and group health insurance plans with 20 or more [*enrollees*] **certificate holders**

on a typical business day during the preceding calendar year.

SECTION 3. ORS 743.610 is amended to read:

743.610. (1) As used in this section:

(a) "Covered person" means an individual who was a certificate holder under a group health insurance policy:

(A) On the day before a qualifying event; and

(B) During the three-month period ending on the date of the qualifying event.

(b) "Qualified beneficiary" means:

(A) A spouse or dependent child of a covered person who, on the day before a qualifying event, was insured under the covered person's group health insurance policy; or

(B) A child born to or adopted by a covered person during the period of the continuation of coverage under this section who would have been insured under the covered person's policy if the child had been born or adopted on the day before the qualifying event.

(c) "Qualifying event" means the loss of membership in a group health insurance policy caused by:

(A) Voluntary or involuntary termination of the employment of a covered person;

(B) A reduction in hours worked by a covered person;

(C) A covered person becoming eligible for Medicare;

(D) A qualified beneficiary losing dependent child status under a covered person's group health insurance policy;

(E) Termination of membership in the group covered by the group health insurance policy; or

(F) The death of a covered person.

(2) A group health insurance policy providing coverage for hospital or medical expenses, other than coverage limited to expenses from accidents or specific diseases, must contain a provision that a covered person and any qualified beneficiary may continue coverage under the policy as provided in this section.

(3) Continuation of coverage is not available to a covered person or qualified beneficiary who is eligible for:

(a) Medicare; or

(b) Coverage for hospital or medical expenses under any other program that was not covering the covered person or qualified beneficiary on the day before a qualifying event.

(4) The continued coverage need not include benefits for dental, vision care or prescription drug expense, or any other benefits under the policy other than hospital and medical expense benefits.

(5) A covered person or qualified beneficiary who wishes to continue coverage must provide the insurer with a written request for continuation no later than 10 days after the later of the date of a qualifying event or the date the insurer provides the notice required by subsection (10) of this section.

(6) A covered person or qualified beneficiary who requests continuation of coverage shall pay the premium on a monthly basis and in advance to the insurer or to the employer or policyholder, whichever the group policy provides. The required premium payment may not exceed the group premium rate for the insurance being continued under the group policy as of the date the premium payment is due.

(7) Continuation of coverage as provided under this section ends on the earliest of the following dates:

(a) Nine months after the date of the qualifying event that was the basis for the continuation

of coverage.

(b) The end of the period for which the last timely premium payment for the coverage is received by the insurer.

(c) The premium payment due date coinciding with or next following the date that continuation of coverage ceases to be available in accordance with subsection (3) of this section.

(d) The date that the policy is terminated. However, if the policyholder replaces the terminated policy with similar coverage under another group health insurance policy:

(A) The covered person and qualified beneficiaries may obtain coverage under the replacement policy for the balance of the period that the covered person or qualified beneficiary would have remained covered under the terminated policy in accordance with this section; and

(B) The terminated policy must continue to provide benefits to the covered person and qualified beneficiaries to the extent of that policy's accrued liabilities and extensions of benefits as if the replacement had not occurred.

(8) A qualified beneficiary who is not eligible for continuation of coverage under ORS 743.600 may continue coverage under this section upon the dissolution of marriage with or the death of the covered person in the same manner that a covered person may exercise the right to continue coverage under this section.

(9) A covered person rehired by an employer no later than nine months after the layoff of the covered person by the employer may not be subjected to a waiting period for coverage under the employer's group health insurance policy if the covered person was eligible for coverage at the time of the layoff, regardless of whether the covered person continued coverage during the layoff.

(10) If an insurer terminates the group health insurance coverage of a covered person or qualified beneficiary without providing replacement coverage that meets the criteria in subsection (7)(d) of this section, the insurer shall provide written notice to the covered person and any qualified beneficiary no later than 10 days after the insurer is notified of the qualifying event under subsection (5) of this section. The notice shall include [*at least the following*] information **prescribed by the Director of the Department of Consumer and Business Services.**[*:*]

[*(a) Contact information for the insurer;*]

[*(b) Forms necessary to request continuation of coverage and instructions for completing the forms;*]

[*(c) Information sufficient to determine premium rates for continuation of coverage and instructions for paying premiums;*]

[*(d) A clear statement of who is eligible to continue coverage;*]

[*(e) Enrollment information relating to other coverage issued by the insurer that is held by the employer or group and for which the covered person or a qualified beneficiary may be eligible;*]

[*(f) An explanation of the process to appeal a denial of a claim under the continuation of coverage;*]

[*(g) Information, in a form approved by the Director of the Department of Consumer and Business Services, about how to contact the consumer advocacy unit of the Insurance Division of the Department of Consumer and Business Services; and*]

[*(h) Other information required by the director.*]

(11) This section applies only to employers who are not required to make available continuation of health insurance benefits under Titles X and XXII of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, P.L. 99-272, April 7, 1986.

SECTION 4. ORS 743.766 is amended to read:

743.766. (1) All carriers that offer an individual health benefit plan and evaluate the health status of individuals for purposes of eligibility shall use the standard health statement established under ORS 743.745 and may not use any other method to determine the health status of an individual. Nothing in this subsection shall prevent a carrier from using health information after enrollment for the purpose of providing services or arranging for the provision of services under a health benefit plan.

(2)(a) If an individual is accepted for coverage under an individual health benefit plan, the carrier shall not impose exclusions or limitations other than:

(A) A preexisting condition exclusion that complies with the following requirements:

(i) The exclusion applies only to a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period immediately preceding the individual's effective date of coverage;

(ii) The exclusion expires no later than six months after the individual's effective date of coverage; and

(iii) Except for grandfathered health plans, the exclusion does not apply to individuals who are under 19 years of age;

(B) An individual coverage waiting period of 90 days; or

(C) An exclusion period for specified covered services applicable to all individuals enrolling for the first time in the individual health benefit plan.

(b) Except for grandfathered health plans, pregnancy of individuals who are under 19 years of age may not constitute a preexisting condition for purposes of this section.

(3) If the carrier elects to restrict coverage through the application of a preexisting condition exclusion or an individual coverage waiting period provision, the carrier shall reduce the duration of the provision by an amount equal to the individual's aggregate periods of creditable coverage if the most recent period of creditable coverage is ongoing or ended within 63 days after the effective date of coverage in the new individual health benefit plan. The crediting of prior coverage in accordance with this subsection shall be applied without regard to the specific benefits covered during the prior period.

(4) If an eligible prospective enrollee is rejected for coverage under an individual health benefit plan, the prospective enrollee shall be eligible to apply for coverage under the Oregon Medical Insurance Pool.

(5) If a carrier accepts an individual for coverage under an individual health benefit plan, the carrier shall renew the policy unless:

(a) The policyholder fails to pay the required premiums.

(b) The policyholder or a representative of the policyholder engages in fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of the policy.

(c) The carrier discontinues offering or renewing, or offering and renewing, all of its individual health benefit plans in this state or in a specified service area within this state. In order to discontinue the plans under this paragraph, the carrier:

(A) Must give notice of the decision to the Department of Consumer and Business Services and to all policyholders covered by the plans;

(B) May not cancel coverage under the plans for 180 days after the date of the notice required under subparagraph (A) of this paragraph if coverage is discontinued in the entire state or, except as provided in subparagraph (C) of this paragraph, in a specified service area;

(C) May not cancel coverage under the plans for 90 days after the date of the notice required

under subparagraph (A) of this paragraph if coverage is discontinued in a specified service area because of an inability to reach an agreement with the health care providers or organization of health care providers to provide services under the plans within the service area; and

(D) Must discontinue offering or renewing, or offering and renewing, all health benefit plans issued by the carrier in the individual market in this state or in the specified service area.

(d) The carrier discontinues offering and renewing an individual health benefit plan in a specified service area within this state because of an inability to reach an agreement with the health care providers or organization of health care providers to provide services under the plan within the service area. In order to discontinue a plan under this paragraph, the carrier:

(A) Must give notice of the decision to the department and to all policyholders covered by the plan;

(B) May not cancel coverage under the plan for 90 days after the date of the notice required under subparagraph (A) of this paragraph; and

(C) Must offer in writing to each policyholder covered by the plan, all other individual health benefit plans that the carrier offers in the specified service area. The carrier shall offer the plans at least 90 days prior to discontinuation.

(e) The carrier discontinues offering or renewing, or offering and renewing, an individual health benefit plan, other than a grandfathered health plan, for all individuals in this state or in a specified service area within this state, other than a plan discontinued under paragraph (d) of this subsection.

(f) The carrier discontinues renewing or offering and renewing a grandfathered health plan for all individuals in this state or in a specified service area within this state, other than a plan discontinued under paragraph (d) of this subsection.

(g) With respect to plans that are being discontinued under paragraph (e) or (f) of this subsection, the carrier must:

(A) Offer in writing to each policyholder covered by the plan, all health benefit plans that the carrier offers to individuals in the specified service area.

(B) Offer the plans at least 90 days prior to discontinuation.

(C) Act uniformly without regard to the claims experience of the affected policyholders or the health status of any current or prospective enrollee.

(h) The Director of the Department of Consumer and Business Services orders the carrier to discontinue coverage in accordance with procedures specified or approved by the director upon finding that the continuation of the coverage would:

(A) Not be in the best interests of the enrollee; or

(B) Impair the carrier's ability to meet its contractual obligations.

(i) In the case of an individual health benefit plan that delivers covered services through a specified network of health care providers, the enrollee no longer lives, resides or works in the service area of the provider network and the termination of coverage is not related to the health status of any enrollee.

(j) In the case of a health benefit plan that is offered in the individual market only through one or more bona fide associations, the membership of an individual in the association ceases and the termination of coverage is not related to the health status of any enrollee.

(6) A carrier may modify an individual health benefit plan at the time of coverage renewal. The modification is not a discontinuation of the plan under subsection (5)(c), (e) and (f) of this section.

(7) Notwithstanding any other provision of this section, and subject to the provisions of ORS 743.894 (2) and (4), a carrier may rescind an individual health benefit plan if the policyholder or a

representative of the policyholder:

(a) Performs an act, practice or omission that constitutes fraud; or

(b) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the policy.

(8) A carrier that withdraws from the market for individual health benefit plans must continue to renew its portability health benefit plans that have been approved pursuant to ORS 743.761.

(9) A carrier that continues to offer coverage in the individual market in this state is not required to offer coverage in all of the carrier's individual health benefit plans. However, if a carrier elects to continue a plan that is closed to new individual policyholders instead of offering alternative coverage in its other individual health benefit plans, the coverage for all existing policyholders in the closed plan is renewable in accordance with subsection (5) of this section.

(10) An individual health benefit plan may not impose **annual or** lifetime limits on the dollar amount of the essential health benefits prescribed by the United States Secretary of Health and Human Services pursuant to 42 U.S.C. 300gg-11, except as permitted by federal law.

(11) This section does not require a carrier to actively market, offer, issue or accept applications for a grandfathered health plan or from an individual not eligible for coverage under such a plan as provided by the Patient Protection and Affordable Care Act (P.L. 111-148) as amended by the Health Care and Education Reconciliation Act (P.L. 111-152).

SECTION 5. ORS 743.801 is amended to read:

743.801. As used in this section and ORS 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, 743.894, 743.911, 743.912, 743.913, 743.917 and 743.918:

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

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

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

(c) Imposition of a preexisting condition exclusion as defined in ORS 743.730, source-of-injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or services;

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

(e) Determination that a course or plan of treatment that an enrollee is undergoing is an active course of treatment for purposes of continuity of care under ORS 743.854.

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

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

(4) "Grievance" means:

(a) A [*request submitted by*] **communication from** an enrollee or an authorized representative of an enrollee **expressing dissatisfaction with an adverse benefit determination, without specifically declining any right to appeal or review, that is**:

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

(B) In writing or orally, for an expedited response described in ORS 743.804 (2)(d) or an expedited external review; or

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

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

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

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

(5) "Health benefit plan" has the meaning given that term in ORS 743.730.

(6) "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.

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

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

(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) "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 6. ORS 743.804 is amended to read:

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

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

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

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

(B) To be treated with respect and with recognition of the enrollee's dignity and need for privacy.

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

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

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

(A) The procedures for requesting an expedited response to an internal appeal under subsection (2)(d) of this section or for requesting an expedited external review of an adverse benefit determination;

(B) A statement that if an insurer does not comply with the decision of an independent review organization under ORS 743.862, the enrollee may sue the insurer under ORS 743.864;

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

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

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

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

(A) Cost-sharing differentials;

(B) Restrictions on coverage;

(C) Prescription drug formularies;

(D) Procedures by which a provider with prescribing authority may prescribe drugs not included on the formulary;

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

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

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

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

(g) How to obtain referrals for specialty care in accordance with ORS 743.856.

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

(i) The availability of continuity of care as required by ORS 743.854.

(j) Procedures for accessing after-hours care and emergency services as required by ORS

743A.012.

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

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

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

(n) A summary of how the insurer makes decisions regarding coverage and payment for treatment or services, including a general description of any prior authorization and utilization control requirements that affect coverage or payment.

(o) Disclosure of any risk-sharing arrangement the insurer has with physicians or other providers.

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

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

(r) Notice of the information available from the department that is filed by insurers as required under ORS 743.807, 743.814 and 743.817.

(2) Establish procedures for making coverage determinations and resolving grievances that provide for all of the following:

(a) Timely notice of adverse benefit determinations in a form and manner approved by the department or prescribed by the department by rule.

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

(c) Written decisions meeting criteria established by the Director of the Department of Consumer and Business Services by rule.

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

(e) At least one but not more than two levels of internal appeal for group health benefit plans and one level of internal appeal for individual and portability health benefit plans. If an insurer provides:

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

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

(f)(A) An external review that meets the requirements of ORS 743.857, 743.859 and 743.861 and is conducted in a manner approved by the department or prescribed by the department by rule, after the enrollee has exhausted internal appeals or after the enrollee has been deemed to have exhausted internal appeals.

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

(g) The opportunity for the enrollee to receive continued coverage **of an approved and ongoing course of treatment** under the health benefit plan pending the conclusion of the internal appeal process.

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

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

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

(3) Establish procedures for notifying affected enrollees of:

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

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

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

(4) Provide the information described in subsection (2) of this section and ORS 743.859 at each level of internal appeal to an enrollee who is notified of an adverse benefit determination or to an enrollee who files a grievance.

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

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

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

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

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

(7) Maintain for a period of at least six years written records that document all grievances described in ORS 743.801 (4)(a) and make the written records available for examination by the department or by an enrollee or authorized representative of an enrollee with respect to a grievance made by the enrollee. The written records must include but are not limited to the following:

(a) Notices and claims associated with each grievance.

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

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

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

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

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

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

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

SECTION 7. ORS 743.806 is amended to read:

743.806. All utilization review performed pursuant to a medical services contract to which an insurer is not a party shall comply with the following:

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

(2) A doctor of medicine or osteopathy licensed under ORS chapter 677 shall be responsible for all final recommendations regarding the necessity or appropriateness of services or the site at which the services are provided and shall consult as appropriate with medical and mental health specialists in making such recommendations.

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

(4) A provider request for prior authorization of nonemergency service must be answered within two business days, and qualified health care personnel must be available for same-day telephone responses to inquiries concerning certification of continued length of stay.

SECTION 8. ORS 743.822 is amended to read:

743.822. (1) As a condition of transacting business in the health benefit plan market in this state, a carrier shall offer to residents of this state bronze and silver plans approved by the Department of Consumer and Business Services as meeting the requirements of subsection (2) of this section in each individual and small group market in which the carrier offers a health benefit plan through the Oregon Health Insurance Exchange or outside of the exchange.

(2) The Director of the Department of Consumer and Business Services shall prescribe by rule the:

(a) Requirements for a bronze plan to ensure that a bronze plan offered in this state is actuarially equivalent to 60 percent of the full actuarial value of benefits included in the essential health benefits package prescribed by the United States Secretary of Health and Human Services under 42 U.S.C. 18022(a).

(b) Requirements for a silver plan to ensure that a silver plan offered in this state is actuarially equivalent to 70 percent of the full actuarial value of benefits included in the essential health benefits package prescribed by the United States Secretary of Health and Human Services under 42 U.S.C. 18022(a).

(c) Form, level of coverage and benefit design for the bronze and silver plans to be used by carriers in the individual and small group market in this state.

(3) As used in this section, "health benefit plan" has the meaning given that term in ORS 743.730.

SECTION 9. (1) Notwithstanding any other provision of law, ORS 743.822 and 743.826 shall not be considered to have been added to or made a part of ORS 743.730 to 743.773 for the purpose of statutory compilation or for the application of definitions, penalties or administrative provisions applicable to statute sections in that series.

(2) Notwithstanding any other provision of law, ORS 743.842 shall not be considered to have been added to or made a part of ORS chapter 743 for the purpose of statutory compilation or for the application of definitions, penalties or administrative provisions applicable to statute sections in that series.

SECTION 10. ORS 743.777 (7), 743.822, 743.826 and 743.842 are added to and made a part of the Insurance Code.

SECTION 11. The amendments to ORS 743.499, 743.601, 743.610, 743.766, 743.801, 743.804, 743.806 and 743.822 by sections 1 to 8 of this 2012 Act apply to policies and certificates issued or renewed on or after June 23, 2011.

SECTION 12. This 2012 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2012 Act takes effect on its passage.
