79th OREGON LEGISLATIVE ASSEMBLY--2017 Regular Session

House Bill 2492

Sponsored by Representative BENTZ (at the request of Dan Herold) (Presession filed.)

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.**

Establishes dispute resolution procedures for charges for emergency services and for unexpected medical bills for out-of-network health care services. Requires insurers to make available process for out-of-network referrals and prior authorizations. Requires insurers to reimburse cost of out-of-network health care services in specified circumstances.

Requires providers to disclose to patients health plans in which providers participate.

Requires Department of Consumer and Business Services to convene out-of-network reimbursement rate task force and specifies membership and duties. Sunsets task force on December 31, 2018.

Makes various changes to requirements in Insurance Code regarding out-of-network providers and notices that must be provided to insureds.

1 **A BILL FOR AN ACT**

2 Relating to health care; creating new provisions; and amending ORS 743.550, 743B.250, 743B.505,
3 746.230 and 750.055.

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

5 **SECTION 1. As used in sections 1 to 6 of this 2017 Act:**

6 **(1) "CPT codes" means the official current procedural terminology codes developed and**
7 **updated by the American Medical Association that are used to report medical procedures and**
8 **services to public and private health insurers.**

9 **(2) "Emergency services" has the meaning given that term in ORS 743A.012.**

10 **(3) "Health insurance plan" means a policy, contract or certificate of health insurance,**
11 **as defined in ORS 731.162.**

12 **(4) "Insured" means a beneficiary of a health insurance plan.**

13 **(5) "Insurer" means a person offering a health insurance plan in this state.**

14 **(6) "Nonparticipating" means not having a contract with a insurer to provide health care**
15 **services to an insured under a health insurance plan offered by the insurer.**

16 **(7) "Participating" means having a contract with an insurer to provide health care ser-**
17 **vices to an insured under a health insurance plan offered by the insurer.**

18 **(8) "Patient" means an individual who receives health care services, including emergency**
19 **services, in this state.**

20 **(9) "Provider" has the meaning given that term in ORS 743B.001.**

21 **(10) "Usual and customary cost" means the 80th percentile of all charges for a particular**
22 **health care service performed by providers in the same or similar specialty and provided in**
23 **the same geographical area as reported in a benchmarking database maintained by a**
24 **nonprofit organization that is specified by the Department of Consumer and Business Ser-**
25 **vices and is not affiliated with an insurer.**

26 **SECTION 2. The Department of Consumer and Business Services shall establish, in ac-**
27 **cordance with sections 1 to 6 of this 2017 Act, procedures for resolving disputes about bills**

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.

for emergency services and bills for health care services rendered by out-of-network providers. The department shall adopt by rule the standards for the dispute resolution procedures, the requirements for certifying independent dispute resolution entities responsible for handling disputes and the process for suspending or revoking the certification of independent dispute resolution entities.

SECTION 3. (1) The dispute resolution procedures established under section 2 of this 2017 Act do not apply to the reimbursement of health care services if a provider's charges for the services are subject to schedules, or other monetary limitations, under any other law, including the Workers' Compensation Law.

(2)(a) With regard to emergency services billed under CPT codes 99281 to 99285, 99288, 99291 to 99292, 99217 to 99220, 99224 to 99226 and 99234 to 99236, the dispute resolution procedures established under section 2 of this 2017 Act do not apply if:

(A) The amount billed under a CPT code meets the requirements in paragraph (c) of this subsection, less the insured's applicable coinsurance, copayment and deductible; and

(B) The amount billed under a CPT code does not exceed 120 percent of the usual and customary cost for the CPT code.

(b) An insured may not be held responsible for out-of-pocket costs for emergency services billed under a CPT code listed in paragraph (a) of this subsection for costs that exceed the costs the insured would have incurred if the emergency services were provided by a participating provider.

(c) Beginning January 2, 2018, and each January 2 thereafter, the Department of Consumer and Business Services shall publish on a website maintained by the department, and provide directly to each insurer, the maximum dollar amount that may be charged or reimbursed for emergency services represented by the CPT codes listed in paragraph (a) of this subsection. The amount must be equal to the amount from the prior year, beginning with $600 in 2017, adjusted by the average of the annual average inflation rates for the medical care commodities and medical care services components of the Consumer Price Index. In no event shall an amount exceeding $1,200 be exempt from the dispute resolution procedures established under section 2 of this 2017 Act.

SECTION 4. In determining a reasonable payment amount for a health care service, an independent dispute resolution entity shall consider all relevant conditions and factors, including:

(1) Whether there is a gross disparity between the provider's charge for the health care service and:

(a) The provider's charge for the same service rendered by the provider to other patients in health insurance plans in which the provider is nonparticipating; and

(b) In the case of a dispute involving a health insurance plan, the reimbursement paid by the insurer, for the same service in the same region, to similarly qualified nonparticipating providers;

(2) The provider's level of training, education and experience;

(3) The provider's usual charge for a comparable service with regard to patients in health insurance plans in which the provider is nonparticipating;

(4) The circumstances and complexity of the health care service provided, including the time and location of the service;

(5) The characteristics of the patient; and

(6) The usual and customary cost of the service.

SECTION 5. (1)(a) When an insurer receives a bill for emergency services from a nonparticipating provider, the insurer shall pay the amount that it determines is reasonable for the emergency services rendered by the provider, less the insured's copayment, coinsurance and deductible, if any. If a nonparticipating provider has not complied with section 7 of this 2017 Act, the insured may not be held responsible for out-of-pocket costs that exceed the costs that the insured would have incurred for emergency services rendered by a participating provider.

(b) A nonparticipating provider or an insurer may submit to an independent dispute resolution entity a request for review of a dispute regarding the reimbursement paid by the insurer or the amount charged by the provider for emergency services.

(c) No later than 30 days after receiving the request for review, the independent dispute resolution entity, with the assistance of a designated licensed health professional in the same or similar specialty as the provider who rendered the service for which the reimbursement paid or amount charged is in dispute, shall determine a reasonable payment amount.

(d) In determining a reasonable payment amount for a service, an independent dispute resolution entity shall select either the insurer's reimbursement or the nonparticipating provider's charge. If the independent dispute resolution entity determines that both the insurer's reimbursement and the nonparticipating provider's charge represent unreasonable extremes, the independent dispute resolution entity may direct both parties to attempt a good faith settlement negotiation. The independent dispute resolution entity may grant the insurer and nonparticipating provider up to 10 business days for the negotiation. The negotiation period runs concurrently with the 30-day period for dispute resolution. If the parties are unable to settle the dispute, the independent dispute resolution entity shall determine a reasonable payment amount based upon the conditions and factors set forth in section 4 of this 2017 Act.

(2)(a) An uninsured patient or a provider may submit to an independent dispute resolution entity a request for review of a dispute regarding a bill for emergency services, subject to any restrictions adopted by rule by the Department of Consumer and Business Services.

(b) No later than 30 days after receiving the request for review, the independent dispute resolution entity shall determine a reasonable payment amount for the service based upon the conditions and factors set forth in section 4 of this 2017 Act.

(c) An uninsured patient is not required to pay a provider's billed charge in order to be eligible to submit the dispute to an independent dispute resolution entity for review.

(3) The determination of an independent dispute resolution entity is binding on the insurer, provider, insured and patient, and is admissible in any administrative or court proceeding between the insurer, provider, insured or patient.

SECTION 6. (1)(a) If an insured assigns to a nonparticipating provider the right to receive reimbursement directly from the insured's health insurance plan for health care services, and the nonparticipating provider has not complied with section 7 of this 2017 Act, the nonparticipating provider may not bill the insured in an amount that is in excess of any applicable copayment, coinsurance and deductible that the insured would have owed had the insured utilized a participating provider.

(b) The insurer shall pay the amount charged by the nonparticipating provider or attempt to negotiate the amount of reimbursement with the nonparticipating provider.

(c) If the insurer's attempt to negotiate the amount of reimbursement is not resolved, the insurer shall pay the nonparticipating provider an amount the insurer determines is reasonable for the services rendered, less the insured's copayment, coinsurance and deductible.

(d) The insurer or the nonparticipating provider may submit to an independent dispute resolution entity a request for review of a dispute regarding the charges or the amount of reimbursement if the insurer or provider submitting the request has complied with the requirements of paragraphs (a), (b) and (c) of this subsection.

(e) The independent dispute resolution entity shall determine a reasonable payment amount for the health care service no later than 30 days after receipt of a request for review.

(f) The independent dispute resolution entity shall select either the insurer's reimbursement or the nonparticipating provider's charge. If the independent dispute resolution entity determines that both the insurer's reimbursement and the nonparticipating provider's charge represent unreasonable extremes, the independent dispute resolution entity may direct both parties to attempt a good faith settlement negotiation. The insurer and nonparticipating provider may be granted up to 10 business days for the negotiation. The negotiation period runs concurrently with the 30-day period for dispute resolution. If the parties are unable to settle the dispute, the independent dispute resolution entity shall determine a reasonable payment amount for the health care service based upon the conditions and factors set forth in section 4 of this 2017 Act.

(2)(a) An insured who does not assign to a nonparticipating health care provider the right to receive reimbursement directly from the insured's health insurance plan, or an uninsured patient, who receives a bill for services from a provider may submit the bill to an independent dispute resolution entity for review.

(b) The independent dispute resolution entity shall determine a reasonable payment amount for the health care service based upon the conditions and factors set forth in section 4 of this 2017 Act.

(c) Insureds and patients are not required to pay a nonparticipating provider's charge in order to be eligible to submit the dispute to the independent dispute resolution entity for review.

(3) The determination of an independent dispute resolution entity shall be binding on the insured, patient, provider and insurer, and shall be admissible in any administrative or court proceeding between the insured or patient and the provider or insurer.

SECTION 7. (1) As used in this section:

(a) "Ambulatory surgical center" has the meaning given that term in ORS 442.015.

(b) "Health plan" includes:

(A) A health benefit plan as defined in ORS 743B.005;

(B) A policy or certificate of health insurance, as defined in ORS 731.162, issued to an individual or small employer in this state; and

(C) A health care service contract offered by a health care service contractor, as defined in ORS 750.005.

(c) "Hospital" has the meaning given that term in ORS 442.015.

(d) "Nonemergency services" means health care services that are not emergency services, as defined in ORS 743A.012.

(e) "Participate" means to contract with an insurer that offers a health plan to be re-

imbursed for health care services provided to patients enrolled in the health plan.

(f) "Provider" means an individual 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.

(2)(a) A provider shall disclose to each patient or prospective patient the health plans in which the provider participates and the hospitals and ambulatory surgical centers with which the provider is affiliated.

(b) The provider shall make the disclosures described in paragraph (a) of this subsection orally at the time the patient makes an appointment and directly in writing, or via posting on an Internet website, prior to rendering nonemergency services in the provider's office or in a hospital or ambulatory surgical center.

(3) If a provider does not participate in the health plan in which a patient is enrolled, the provider shall disclose to the patient:

(a) Prior to rendering any nonemergency services, that the amount or estimated amount that the provider will bill the patient for the services will be made available to the patient upon request; and

(b) In writing, and upon request by the patient, the amount or estimated amount that the provider will bill the patient, absent unforeseen medical circumstances that may arise at the time the services are rendered.

(4) A provider who participates in a health plan in which a patient is enrolled shall provide to the patient, prior to the patient's scheduled admission to a hospital or receipt of outpatient hospital services:

(a) The name, practice name, mailing address and telephone number of any other provider whose services will be arranged by the provider and are scheduled at the time of the preadmission testing, registration or admission for nonemergency services; and

(b) Information as to how to determine the health plans in which the other provider participates.

(5) A hospital shall post on the hospital's Internet website:

(a) The health plans in which the hospital participates;

(b) A statement that:

(A) Indicates the types of providers whose services are not included in the hospital's charges;

(B) Providers who provide health care services in the hospital may or may not participate in the same health plans as the hospital; and

(C) The patient should check with the provider arranging for the hospital services to determine the health plans in which the provider participates;

(c) As applicable, the name, mailing address and telephone number of each provider group with which the hospital has contracted to provide health care services, including anesthesiology, pathology and radiology, and instructions on how to contact the provider group in order to determine the health plans in which the provider group participates; and

(d) As applicable, the name, mailing address and telephone number of each provider employed by the hospital, whose services may be rendered at the hospital, and the health plans in which the provider participates.

(6) In registration or admission materials provided in advance of nonemergency services provided at a hospital, the hospital shall:

(a) Advise a patient or prospective patient to check with the provider arranging the hospital services to determine:

(A) The name, practice name, mailing address and telephone number of any other provider whose services will be arranged by the provider; and

(B) Whether the services of providers who are contracted or employed by the hospital to render services, including anesthesiology, pathology and radiology, are reasonably anticipated to be provided to the patient; and

(b) Provide a patient or prospective patient with information as to how to timely determine the health plans in which the providers described in paragraph (a) of this subsection participate.

<u>SECTION 8.</u> **(1) The Department of Consumer and Business Services shall convene an out-of-network reimbursement rate task force consisting of:**

(a) Nine members appointed by the Governor;

(b) Two members appointed on the recommendation of the Speaker of the House of Representatives; and

(c) Two members appointed on the recommendation of the President of the Senate.

(2) The membership of the task force must include at least two providers, two representatives of health insurers and three consumers of health care and represent all geographic regions of this state.

(3) The task force shall review the current out-of-network reimbursement rate and methodology used by insurers offering health insurance in this state and make recommendations regarding an alternative rate methodology, taking into consideration the following factors:

(a) Current provider charges for out-of-network services;

(b) Trends in medical care and the actual costs of medical care;

(c) Regional differences in medical costs and trends in this state;

(d) The current methodologies and rates of reimbursement for out-of-network services paid by health insurers in this state, including health care service contractors as defined in ORS 750.005, Medicare supplemental policies and the state medical assistance program;

(e) The current in-network rates paid by health plans, including insurers, health care service contractors as defined in ORS 750.005, Medicare supplemental policies and the state medical assistance program, for the same service by the same provider;

(f) The impact of different rate methodologies on the out-of-pocket costs for consumers who access out-of-network services;

(g) The impact different rate methodologies have on premium costs in different regions of this state;

(h) Reimbursement data from all health plans both public and private and data reported under ORS 413.032 (2) and 442.466; and

(i) Other issues deemed appropriate by the department.

(4) The task force shall review out-of-network coverage in the individual and small group markets and make recommendations regarding the availability and adequacy of the coverage, taking into consideration the following factors:

(a) The extent to which out-of-network coverage is available in each rating region in this state;

(b) The extent to which a significant level of out-of-network benefits is available in every

rating region in this state, including the prevalence of coverage based on the usual and customary cost as well as coverage based on other reimbursement methodologies, such as Medicare; and

(c) Other issues deemed appropriate by the Director of the Department of Consumer and Business Services.

(5) The task force shall submit a report in the manner provided by ORS 192.245, which may include recommendations for legislation, to the interim committees of the Legislative Assembly related to health no later than September 15, 2018.

(6) The department shall provide staff support to the task force.

(7) Notwithstanding ORS 171.072, members of the task force who are members of the Legislative Assembly are not entitled to mileage expenses or a per diem and serve as volunteers on the task force. Other members of the task force are not entitled to compensation or reimbursement for expenses and serve as volunteers on the task force.

(8) All agencies of state government, as defined in ORS 174.111, are directed to assist the task force in the performance of the task force's duties and, to the extent permitted by laws relating to confidentiality, to furnish information and advice the members of the task force consider necessary to perform their duties.

SECTION 9. ORS 743.550 is amended to read:

743.550. (1) Student health insurance is subject to ORS 743.537, 743.540, 743.543, 743.546**,** [*and*] 743B.475, **743B.250 and 743B.505,** except as provided in this section.

(2) Coverage under a student health insurance policy may be mandatory for all students at the institution, voluntary for all students at the institution, or mandatory for defined classes of students and voluntary for other classes of students. As used in this subsection, "classes" refers to undergraduates, graduate students, domestic students, international students or other like classifications. Any differences based on a student's nationality may be established only for the purpose of complying with federal law in effect when the policy is issued.

(3) When coverage under a student health insurance policy is mandatory, the policyholder may allow any student subject to the policy to decline coverage if the student provides evidence acceptable to the policyholder that the student has similar health coverage.

(4) A student health insurance policy may provide for any student to purchase optional supplemental coverage.

(5) Student health insurance coverage for athletic injuries may:

(a) Exclude coverage for injuries of students who have not obtained medical release for a similar injury; and

(b) Be provided in excess of or in addition to any other coverage under any other health insurance policy, including a student health insurance policy.

(6) A student health insurance policy may provide that coverage under the policy is secondary to any other health insurance for purposes of guidelines established under ORS 743B.475.

(7) A student health insurance policy may provide, on request by the policyholder, that all or any portion of any indemnities provided by such policy on account of hospital, nursing, medical or surgical services may, at the insurer's option, be paid directly to the hospital or person rendering such services. However, the amount of any such payment shall not exceed the amount of benefit provided by the policy with respect to the service or billing of the provider of aid. The amount of such payments pursuant to one or more assignments shall not exceed the amount of expenses incurred on account of such hospitalization or medical or surgical aid.

(8) An insurer providing student health insurance as primary coverage may negotiate and enter into contracts for alternative rates of payment with providers and offer the benefit of such alternative rates to insureds who select such providers. An insurer may utilize such contracts by offering a choice of plans at the time an insured enrolls, one of which provides benefits only for services by members of a particular provider organization with whom the insurer has an agreement. If an insured chooses such a plan, benefits are payable only for services rendered by a member of that provider organization, unless such services were requested by a member of such organization or are rendered as the result of an emergency.

(9) Payments made under subsection (8) of this section shall discharge the insurer's obligation with respect to the amount of insurance paid.

(10) An insurer shall provide each student health insurance policyholder with a current roster of institutional and professional providers under contract to provide services at alternative rates under the group policy and shall also make such lists available for public inspection during regular business hours at the insurer's principal office within this state.

(11) As used in this section, "student health insurance":

(a) Means that form of health insurance under a policy issued to a college, school or other institution of learning, a school district or districts, or school jurisdictional unit, or recognized student government at a public university listed in ORS 352.002, or to the head, principal or governing board of any such educational unit, who or which shall be deemed the policyholder, that is available exclusively to students at the college, school or other institution.

(b) Does not include a student health benefit plan as defined in ORS 743.551.

SECTION 10. ORS 743B.250, as amended by section 5, chapter 59, Oregon Laws 2015, is amended to read:

743B.250. 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 743B.256, the enrollee may sue the insurer under ORS 743B.258;

(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. The list must be available online and upon request in printed format.

(f) Notice of the enrollee's right to select a primary care provider and specialty care providers**, including the right to select as a primary care provider a women's health care provider as required by ORS 743B.222**.

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

(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 743B.225.

(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 and the requirement under ORS 743B.555 that a carrier or third party administrator send communications containing protected health information only to the enrollee who is the subject of the protected health 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 743B.200, 743B.202 and 743B.423.

(s) A description of the procedure for obtaining estimates of the costs of services provided by in-network and out-of-network providers under ORS 743B.281 and 743B.282.

(t) The requirements applicable to the insurer's network of health care providers under ORS 743B.505.

(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 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 743B.252, 743B.254 and 743B.255 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 743B.254 **and the dispute resolution procedures described in sections 1 to 6 of this 2017 Act** 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 743B.001 (7)(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 11. ORS 743B.505 is amended to read:

743B.505. (1) An insurer offering a health benefit plan in this state that provides coverage to individuals or to small employers, as defined in ORS 743B.005, through a specified network of health care providers shall:

(a) Contract with or employ a network of providers that is sufficient in number, geographic distribution and types of providers to ensure that all covered services under the health benefit plan, including mental health and substance abuse treatment, are accessible to enrollees without unreasonable delay.

(b)(A) With respect to health benefit plans offered through the health insurance exchange under ORS 741.310, contract with a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of essential community providers for low-income, medically underserved individuals in the plan's service area in accordance with the network adequacy standards established by the Department of Consumer and Business Services;

(B) If the health benefit plan offered through the health insurance exchange offers a majority of the covered services through physicians employed by the insurer or through a single contracted medical group, have a sufficient number and geographic distribution of employed or contracted providers and hospital facilities to ensure reasonable and timely access for low-income, medically underserved enrollees in the plan's service area, in accordance with network adequacy standards adopted by the Department of Consumer and Business Services; or

(C) With respect to health benefit plans offered outside of the health insurance exchange, contract with or employ a network of providers that is sufficient in number, geographic distribution and types of providers to ensure access to care by enrollees who reside in locations within the health benefit plan's service area that are designated by the Health Resources and Services Administration of the United States Department of Health and Human Services as health professional shortage areas or low-income zip codes.

(c) Annually report to the Department of Consumer and Business Services, in the format prescribed by the department, the insurer's plan for ensuring that the network of providers for each health benefit plan meets the requirements of this section.

(2)(a) An insurer may not discriminate with respect to participation under a health benefit plan or coverage under the plan against any health care provider who is acting within the scope of the provider's license or certification in this state.

(b) This subsection does not require an insurer to contract with any health care provider who is willing to abide by the insurer's terms and conditions for participation established by the insurer.

(c) This subsection does not prevent an insurer from establishing varying reimbursement rates based on quality or performance measures.

(d) Rules adopted by the Department of Consumer and Business Services to implement this section shall be consistent with the provisions of 42 U.S.C. 300gg-5 and the rules adopted by the United States Department of Health and Human Services, the United States Department of the Treasury or the United States Department of Labor to carry out 42 U.S.C. 300gg-5.

(3) The Department of Consumer and Business Services shall use one of the following methods in evaluating whether the network of providers available to enrollees in a health benefit plan meets the requirements of this section:

(a) An approach by which an insurer submits evidence that the insurer is complying with at least one of the factors prescribed by the department by rule from each of the following categories:

(A) Access to care consistent with the needs of the enrollees served by the network;

(B) Consumer satisfaction;

(C) Transparency; and

(D) Quality of care and cost containment; or

(b) A nationally recognized standard adopted by the department and adjusted, as necessary, to reflect the age demographics of the enrollees in the plan.

(4) This section does not require an insurer to contract with an essential community provider that refuses to accept the insurer's generally applicable payment rates for services covered by the plan.

(5) This section does not require an insurer to submit provider contracts to the department for review.

(6) An insurer shall provide a referral or prior authorization for an insured to obtain services from an out-of-network provider if the insurer's network of health care providers does not include a provider who is geographically accessible to the insured and who has the appropriate training and experience to meet the particular health care needs of the insured.

(7) If an insurer denies a referral or prior authorization under subsection (6) of this section, the insurer shall notify the insured in writing of the insured's right to internal appeals and requests for external review under ORS 743B.250 and 743B.252.

(8)(a) An insurer that reimburses the cost of services provided by out-of-network providers shall make available at least one option for reimbursement of at least 80 percent of the usual and customary cost of the services after imposition of a deductible or any permissible benefit maximum. The Department of Consumer and Business Services may waive the requirements of this subsection, upon the request of an insurer, if the department determines that compliance with this subsection would impose an undue hardship on the insurer.

(b) As used in this subsection, "usual and customary cost" means the 80th percentile of all charges for a service performed by providers in the same or similar specialty and provided in the same geographic area.

SECTION 12. ORS 746.230, as amended by section 6, chapter 59, Oregon Laws 2015, is amended

to read:

746.230. (1) No insurer or other person shall commit or perform any of the following unfair claim settlement practices:

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

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

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

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

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

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

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

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

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

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

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

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

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

(n) Submitting reasonable claims for reimbursement to an independent dispute resolution entity under section 5 or 6 of this 2017 Act.

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

(a) A substantial increase in the number of complaints against the insurer received by the Department of Consumer and Business Services;

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

(c) Other relevant evidence.

SECTION 13. ORS 750.055, as amended by section 7, chapter 59, Oregon Laws 2015, 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, 731.870 and 743A.252.

(b) 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.

(c) 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.

(d) 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.

(e) ORS chapter 734.

(f) ORS 735.600 to 735.650.

(g) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to 742.540, 743.004, 743.008, 743.010, 743.018, 743.022, 743.023, 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.406, 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650 to 743.656, 743.680 to 743.689, 743.788, 743.790, 743A.010, 743A.012, 743A.020, 743A.034, 743A.036, 743A.048, 743A.051, 743A.058, 743A.062, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144, 743A.148, 743A.150, 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743B.003 to 743B.127, 743B.195 to 743B.206, 743B.220, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, **743B.282, 743B.283,** 743B.300, 743B.310, 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.343 to 743B.347, 743B.400, 743B.403, 743B.407, 743B.420, 743B.423, 743B.450, 743B.451, 743B.452, 743B.453, 743B.470, 743B.475, 743B.505, 743B.550, 743B.555, 743B.601 and 743B.800 and section 2, chapter 771, Oregon Laws 2013**, and sections 1 to 6 of this 2017 Act**.

(h) The provisions of ORS chapter 744 relating to the regulation of insurance producers and third party administrators.

(i) 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.

(j) 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, physician assistant or nurse practitioner associated with a group practice health maintenance organization.

(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 14. ORS 750.055, as amended by section 33, chapter 698, Oregon Laws 2013, section 6, chapter 25, Oregon Laws 2014, section 81, chapter 45, Oregon Laws 2014, section 8, chapter 59, Oregon Laws 2015, section 6, chapter 100, Oregon Laws 2015, section 6, chapter 224, Oregon Laws 2015, section 10, chapter 362, Oregon Laws 2015, section 9, chapter 470, Oregon Laws 2015, and section 29, chapter 515, Oregon Laws 2015, is amended to read:

750.055. (1) The following provisions of the Insurance Code apply to health care service con-

tractors 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, 731.870 and 743A.252.

(b) 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.

(c) 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.

(d) 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.

(e) ORS chapter 734.

(f) ORS 735.600 to 735.650.

(g) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to 742.540, 743.004, 743.008, 743.010, 743.018, 743.022, 743.023, 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.406, 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650 to 743.656, 743.680 to 743.689, 743.788, 743.790, 743A.010, 743A.012, 743A.020, 743A.034, 743A.036, 743A.048, 743A.051, 743A.058, 743A.062, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144, 743A.148, 743A.150, 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743B.003 to 743B.127, 743B.195 to 743B.206, 743B.220, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, **743B.282, 743B.283,** 743B.300, 743B.310, 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.343 to 743B.347, 743B.400, 743B.403, 743B.407, 743B.420, 743B.423, 743B.450, 743B.451, 743B.452, 743B.453, 743B.470, 743B.475, 743B.505, 743B.550, 743B.555, 743B.601 and 743B.800 and section 2, chapter 771, Oregon Laws 2013**, and sections 1 to 6 of this 2017 Act**.

(h) The provisions of ORS chapter 744 relating to the regulation of insurance producers and third party administrators.

(i) 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.

(j) 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, physician assistant or nurse practitioner associated with a group practice health maintenance organization.

(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 15. ORS 750.055, as amended by section 21, chapter 771, Oregon Laws 2013, section 7, chapter 25, Oregon Laws 2014, section 82, chapter 45, Oregon Laws 2014, section 9, chapter 59,

Oregon Laws 2015, section 7, chapter 100, Oregon Laws 2015, section 7, chapter 224, Oregon Laws 2015, section 11, chapter 362, Oregon Laws 2015, section 10, chapter 470, Oregon Laws 2015, and section 30, chapter 515, Oregon Laws 2015, 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, 731.870 and 743A.252.

(b) 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.

(c) 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.

(d) 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.

(e) ORS chapter 734.

(f) ORS 735.600 to 735.650.

(g) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to 742.540, 743.004, 743.008, 743.010, 743.018, 743.022, 743.023, 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.406, 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650 to 743.656, 743.680 to 743.689, 743.788, 743.790, 743A.010, 743A.012, 743A.020, 743A.034, 743A.036, 743A.048, 743A.051, 743A.058, 743A.062, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144, 743A.148, 743A.150, 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743B.003 to 743B.127, 743B.195 to 743B.206, 743B.220, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, **743B.282, 743B.283,** 743B.300, 743B.310, 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.343 to 743B.347, 743B.400, 743B.403, 743B.407, 743B.420, 743B.423, 743B.450, 743B.451, 743B.452, 743B.453, 743B.470, 743B.475, 743B.505, 743B.550, 743B.555, 743B.601 and 743B.800 **and sections 1 to 6 of this 2017 Act**.

(h) The provisions of ORS chapter 744 relating to the regulation of insurance producers and third party administrators.

(i) 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.

(j) 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, physician assistant or nurse practitioner associated with a group practice health maintenance organization.

(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

1 and 750.045 that are deemed necessary for the proper administration of these provisions.
2 SECTION 16. **(1) Sections 1 to 6 of this 2017 Act apply to bills or claims for reimburse-**
3 **ment that are for services provided on or after the effective date of this 2017 Act.**
4 **(2) Sections 1 to 6 of this 2017 Act and the amendments to ORS 743.550, 743B.250,**
5 **743B.505, 746.230 and 750.055 by sections 9 to 15 this 2017 Act apply to policies or certificates**
6 **of health insurance issued or renewed on or after the effective date of this 2017 Act.**
7 **SECTION 17. Section 8 of this 2017 Act is repealed on December 31, 2018.**
8