House Bill 2778

Sponsored by COMMITTEE ON HEALTH CARE

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.**

Prohibits insurer, Public Employees' Benefit Board and Oregon Educators Benefit Board from offering benefit plans that require prior authorization or increased cost-sharing for specified health care services if cost of services is reimbursed by plan.

Prohibits health insurer from requesting refund of payment made on claim if treatment was approved by health insurer, and health insurer confirmed coverage of service with health care provider in writing, online or by telephone.

A BILL FOR AN ACT

Relating to payments for health care by health benefit plans; creating new provisions; and amending ORS 743B.451.

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

SECTION 1. Section 2 of this 2017 Act is added to and made a part of the Insurance Code.

SECTION 2. (1) As used in this section, "new episode of care" means treatment for a new or recurrent condition for which the enrollee in the plan has not been treated by the provider within the previous 90 days and is not currently undergoing any active treatment.

(2) An insurer offering a health benefit plan, as defined in ORS 743B.005, that reimburses the cost of chiropractic care, physical therapy, occupational therapy, acupuncture, massage therapy, speech therapy or hearing therapy may not:

(a) Require prior authorization for:

(A) An initial treatment visit with a contracting provider of such a service with respect to a new episode of care; or

(B) Follow-up and management of the treatment by the provider of the service.

(b) Impose for such services copayment or coinsurance requirements or deductibles that exceed the copayment and coinsurance requirements and deductibles required under the plan for physician services.

(3) This section is exempt from ORS 743A.001.

SECTION 3. Section 4 of this 2017 Act is added to and made a part of ORS 243.105 to 243.285.

SECTION 4. (1) As used in this section, "new episode of care" means treatment for a new or recurrent condition for which the enrollee in the plan has not been treated by the provider within the previous 90 days and is not currently undergoing any active treatment.

(2) A benefit plan offered by the Public Employees' Benefit Board that reimburses the cost of chiropractic care, physical therapy, occupational therapy, acupuncture, massage therapy, speech therapy or hearing therapy may not:

(a) Require prior authorization for:

(A) An initial treatment visit with a contracting provider of such a service with respect

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

to a new episode of care; or

(B) Follow-up and management of the treatment by the provider of the service.

(b) Impose for such services copayment or coinsurance requirements or deductibles that exceed the copayment and coinsurance requirements and deductibles required under the plan for physician services.

SECTION 5. Section 6 of this 2017 Act is added to and made a part of ORS 243.860 to 243.886.

SECTION 6. (1) As used in this section, "new episode of care" means treatment for a new or recurrent condition for which the enrollee in the plan has not been treated by the provider within the previous 90 days and is not currently undergoing any active treatment.

(2) A benefit plan offered by the Oregon Educators Benefit Board that reimburses the cost of chiropractic care, physical therapy, occupational therapy, acupuncture, massage therapy, speech therapy or hearing therapy may not:

(a) Require prior authorization for:

(A) An initial treatment visit with a contracting provider of such a service with respect to a new episode of care; or

(B) Follow-up and management of the treatment by the provider of the service.

(b) Impose for such services copayment or coinsurance requirements or deductibles that exceed the copayment and coinsurance requirements and deductibles required under the plan for physician services.

SECTION 7. ORS 743B.451 is amended to read:

743B.451. (1) As used in this section[,]**:**

(a) "Overpayment" means the amount of a health insurer's payment to a health care provider that exceeds:

(A) The amount billed by the health care provider; or

(B) The amount billed by the health care provider as properly adjusted to reflect the contractual agreement between the health care provider and the health insurer.

(b) "Refund" means the return, either directly or through an offset to a future claim, of some or all of a payment already received by a health care provider.

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

(a) Request from a health care provider a refund of a payment previously made to satisfy a claim for reimbursement of a covered service if the health insurer in writing, online or by telephone:

(A) Approved the treatment; and

(B) Confirmed coverage of the service with the health care provider.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(8) This section applies to health benefit plans.

SECTION 8. Sections 2, 4 and 6 of this 2017 Act apply to benefit plans issued or renewed on or after January 1, 2018.
