

DRAFT

SUMMARY

Requires insurer, Public Employees' Benefit Board and Oregon Educators Benefit Board to cover specified health services without prior authorization in health benefit plans and benefit plans offered by insurer or board. Prescribes minimum number of visits that must be covered.

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

1
2 Relating to health insurance coverage; creating new provisions; and amend-
3 ing ORS 743B.451.

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

5 **SECTION 1. Section 2 of this 2019 Act is added to and made a part**
6 **of the Insurance Code.**

7 **SECTION 2. (1) As used in this section:**

8 (a) **“Health benefit plan” has the meaning given that term in ORS**
9 **743B.005.**

10 (b) **“New episode of care” means treatment for a new or recurrent**
11 **condition for which an enrollee in a health benefit plan has not been**
12 **treated by a provider within the previous 90 days and is not currently**
13 **undergoing any active treatment.**

14 (c) **“Provider” means a licensed provider that contracts with an**
15 **insurer to provide:**

16 (A) **Chiropractic care;**

17 (B) **Acupuncture; or**

1 (C) **Massage therapy.**

2 (d) **“Visit” means, with respect to a provider of acupuncture, an**
3 **interaction between a provider and an enrollee for a period of no less**
4 **than 30 minutes.**

5 (2) **An insurer offering a health benefit plan that reimburses the**
6 **cost of chiropractic care, acupuncture or massage therapy shall reim-**
7 **burse in each plan year, without prior authorization, the cost of:**

8 (a) **An initial evaluation by a provider with respect to a new episode**
9 **of care; and**

10 (b) **Follow-up and management of the treatment for any condition**
11 **that is within the provider’s scope of practice for the lesser of six visits**
12 **or up to the maximum number of visits prescribed by the policy or**
13 **certificate of the health benefit plan.**

14 (3) **In addition to the visits for follow-up and management described**
15 **in subsection (2) of this section, the insurer must approve a minimum**
16 **of the lesser of six additional visits or up to the maximum number of**
17 **visits prescribed by the policy or certificate of the health benefit plan**
18 **if the provider submits documentation, as prescribed by the Depart-**
19 **ment of Consumer and Business Services by rule, showing meaningful**
20 **improvement in the enrollee’s condition as a result of the initial**
21 **treatments.**

22 (4) **This section is exempt from ORS 743A.001.**

23 **SECTION 3. Section 4 of this 2019 Act is added to and made a part**
24 **of ORS 243.105 to 243.285.**

25 **SECTION 4. (1) As used in this section:**

26 (a) **“New episode of care” means treatment for a new or recurrent**
27 **condition for which an enrollee in a benefit plan has not been treated**
28 **by a provider within the previous 90 days and is not currently under-**
29 **going any active treatment.**

30 (b) **“Provider” means a licensed provider that contracts with the**
31 **Public Employees’ Benefit Board to provide:**

1 (A) Chiropractic care;

2 (B) Acupuncture; or

3 (C) Massage therapy.

4 (c) "Visit" means, with respect to a provider of acupuncture, an
5 interaction between a provider and an enrollee for a period of no less
6 than 30 minutes.

7 (2) A benefit plan offered by the board that reimburses the cost of
8 chiropractic care, acupuncture or massage therapy shall reimburse in
9 each plan year, without prior authorization, the cost of:

10 (a) An initial evaluation by a provider with respect to a new episode
11 of care; and

12 (b) Follow-up and management of the treatment for any condition
13 that is within the provider's scope of practice for the lesser of six visits
14 or up to the maximum number of visits allowed under the benefit plan.

15 (3) In addition to the visits for follow-up and management described
16 in subsection (2) of this section, the board or a third party adminis-
17 trator on behalf of the board must approve a minimum of the lesser
18 of six additional visits or up to the maximum number of visits allowed
19 under the benefit plan if the provider submits documentation, as pre-
20 scribed by the Department of Consumer and Business Services by rule,
21 showing meaningful improvement in the enrollee's condition as a re-
22 sult of the initial treatments.

23 **SECTION 5.** Section 6 of this 2019 Act is added to and made a part
24 of ORS 243.860 to 243.886.

25 **SECTION 6.** (1) As used in this section:

26 (a) "New episode of care" means treatment for a new or recurrent
27 condition for which an enrollee in a benefit plan has not been treated
28 by a provider within the previous 90 days and is not currently under-
29 going any active treatment.

30 (b) "Provider" means a licensed provider that contracts with the
31 Oregon Educators Benefit Board to provide:

1 (A) Chiropractic care;

2 (B) Acupuncture; or

3 (C) Massage therapy.

4 (c) "Visit" means, with respect to a provider of acupuncture, an
5 interaction between a provider and an enrollee for a period of no less
6 than 30 minutes.

7 (2) A benefit plan offered by the board that reimburses the cost of
8 chiropractic care, acupuncture or massage therapy shall reimburse in
9 each plan year, without prior authorization, the cost of:

10 (a) An initial evaluation by a provider with respect to a new episode
11 of care; and

12 (b) Follow-up and management of the treatment for any condition
13 that is within the provider's scope of practice for the lesser of six visits
14 or up to the maximum number of visits allowed under the benefit plan.

15 (3) In addition to the visits for follow-up and management described
16 in subsection (2) of this section, the board or a third party adminis-
17 trator on behalf of the board must approve a minimum of the lesser
18 of six additional visits or up to the maximum number of visits allowed
19 under the benefit plan if the provider submits documentation, as pre-
20 scribed by the Department of Consumer and Business Services by rule,
21 showing meaningful improvement in the enrollee's condition as a re-
22 sult of the initial treatments.

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

24 743B.451. (1) As used in this section[,]:

25 (a) "Overpayment" means the amount of a health insurer's pay-
26 ment to a health care provider that exceeds:

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

28 (B) The amount billed by the health care provider as properly ad-
29 justed to reflect the contractual agreement between the health care
30 provider and the health insurer.

31 (b) "Refund" means the return, either directly or through an offset to a

1 future claim, of some or all of a payment already received by a health care
2 provider.

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

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

9 (A) **Approved the treatment; and**

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

11 [(a)] (b) Request from a health care provider a refund of a payment pre-
12 viously made to satisfy a claim unless the health insurer:

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

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

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

20 (3) A health insurer may not do the following for reasons related to co-
21 ordination of benefits with another health insurer or entity responsible for
22 payment of a claim:

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

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

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

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

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

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

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

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

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

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

21 (7) This section neither permits nor precludes a health insurer from re-
22 covering from a subscriber, enrollee or beneficiary any amounts paid to a
23 health care provider for benefits to which the subscriber, enrollee or benefi-
24 ciary was not entitled under the terms and conditions of the health plan,
25 insurance policy or other benefit agreement.

26 (8) This section applies to health benefit plans.

27 **SECTION 8. (1) Sections 2, 4 and 6 of this 2019 Act apply to health**
28 **benefit plans or benefit plans issued, renewed or extended on or after**
29 **the effective date of this 2019 Act.**

30 **(2) The amendments to ORS 743B.451 by section 7 of this 2019 Act**
31 **apply to claims which are approved by a health insurer in writing,**

1 **online or by telephone on or after the effective date of this 2019 Act.**

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