LC 60
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D R A F T

SUMMARY

Defines "limited benefit coverage." Excludes health insurance offering limited benefit coverage from certain statutory requirements for health insurance coverage.

A BILL FOR AN ACT

Relating to exclusion of specified types of health insurance from statutory health insurance coverage requirements; creating new provisions; and amending ORS 743.652, 743A.144, 743A.148, 743A.160 and 743A.168.

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

SECTION 1. Section 2 of this 2016 Act is added to and made a part of the Insurance Code.

SECTION 2. "Limited benefit coverage" means:

(1) Health insurance that provides:

(a) Coverage for accident only, specific disease or condition only, credit or disability income;

(b) Dental only coverage; or

(c) Vision only coverage; and

(2) Independent, noncoordinated, hospital-only indemnity insurance or other fixed indemnity insurance.

SECTION 3. ORS 743.652 is amended to read:

743.652. As used in ORS 743.650 to 743.665, unless the context requires otherwise:

(1) "Applicant" means:

(a) In the case of an individual long term care insurance policy, the per-

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.

son who seeks to contract for benefits; and

(b) In the case of a group long term care insurance policy, the proposed certificate holder.

(2) "Benefit trigger" means a contractual provision in a long term care insurance policy that conditions the payment of benefits on an insured's inability to perform activities of daily living or on an insured's cognitive impairment. For qualified long term care insurance, the "benefit trigger" is the determination that an insured is a chronically ill individual, as defined in section 7702B(c) of the Internal Revenue Code.

(3) "Certificate" means any certificate issued under a group long term care insurance policy, if the policy has been delivered or issued for delivery in this state.

(4) "Group long term care insurance" means a long term care insurance policy that is delivered or issued for delivery in this state and issued to:

(a) One or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations;

(b) Any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association:

(A) Is composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation; and

(B) Has been maintained in good faith for purposes other than obtaining insurance;

(c)(A) An association or a trust or the trustee of a fund established, created or maintained for the benefit of members of one or more associations. Prior to advertising, marketing or offering the policy within this state, the association or associations, or the insurer of the association or associations shall file evidence with the director that the association or associations have been organized and maintained in good faith for purposes other than that

of obtaining insurance; have been in active existence for at least one year; and have a constitution and bylaws that provide that:

(i) The association or associations hold regular meetings not less than annually to further purposes of the members;

(ii) Except for credit unions, the association or associations collect dues or solicit contributions from members; and

(iii) The members have voting privileges and representation on the governing board and committees; and

(B) Sixty days after the filing, the association or associations shall be considered to satisfy the organizational requirements, unless the director makes a finding that the association or associations do not satisfy those organizational requirements; or

(d) A group other than as described in paragraphs (a), (b) and (c) of this subsection, subject to a finding by the director that:

(A) The issuance of the group policy is not contrary to the best interest of the public;

(B) The issuance of the group policy would result in economies of acquisition or administration; and

(C) The benefits are reasonable in relation to the premiums charged.

(5) "Long term care insurance" means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than 24 consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one or more necessary or medically necessary services, including but not limited to nursing, diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. "Long term care insurance" includes group and individual annuities and life insurance policies or riders that provide directly or supplement long term care insurance. "Long term care insurance" also includes a policy or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity, and qualified long term care insurance contracts.

Long term care insurance may be issued by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; or health maintenance organizations, health care service contractors or any similar organization to the extent they are otherwise authorized to issue life or health insurance. "Long term care insurance" does not include any insurance policy that is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset protection coverage, catastrophic coverage, accident only coverage, specified disease or specified accident coverage or limited benefit [*health*] coverage. With regard to life insurance, "long term care insurance" does not include life insurance policies that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and when neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long term care. Notwithstanding any other provision of ORS 743.650 to 743.665, any product advertised, marketed or offered as long term care insurance is subject to ORS 743.650 to 743.665.

(6) "Policy" means any policy, contract, subscriber agreement, rider or indorsement delivered or issued for delivery in this state by an insurer; fraternal benefit society; nonprofit health, hospital or medical service corporation; prepaid health plan; or health maintenance organization, health care service contractor or any similar organization.

(7) "Qualified long term care insurance" means:

(a) The portion of a life insurance contract that provides long term care insurance coverage by rider or as part of the contract and that satisfies the requirements of section 7702B(b) and (e) of the Internal Revenue Code; or

(b) Individual or group long term care insurance as defined in this section that meets all of the following requirements of section 7702B(b) of the

Internal Revenue Code:

(A) The only insurance protection provided under the contract is coverage of qualified long term care services. A contract shall not fail to satisfy the requirements of this subparagraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

(B) The contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act, or would be reimbursable but for the application of a deductible or coinsurance amount. The requirements of this subparagraph do not apply to expenses that are reimbursable under Title XVIII of the Social Security Act only as a secondary payer. A contract does not fail to satisfy the requirements of this subparagraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

(C) The contract is guaranteed renewable within the meaning of section 7702B(b)(1)(C) of the Internal Revenue Code.

(D) The contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed except as provided in subparagraph (E) of this paragraph.

(E) All refunds of premiums, and all policyholder dividends or similar amounts, under the contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund on the event of death of the insured or a complete surrender or cancellation of the contract cannot exceed the aggregate premiums paid under the contract.

(F) The contract meets the consumer protection provisions set forth in section 7702B(g) of the Internal Revenue Code.

SECTION 4. ORS 743A.144 is amended to read:

743A.144. (1) All individual and group health insurance policies providing coverage for hospital, medical or surgical expenses**, other than limited benefit coverage,** shall include coverage for prosthetic and orthotic devices

that are medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that are not solely for comfort or convenience. The coverage required by this subsection includes all services and supplies medically necessary for the effective use of a prosthetic or orthotic device, including formulating its design, fabrication, material and component selection, measurements, fittings, static and dynamic alignments, and instructing the patient in the use of the device.

(2) As used in this section:

(a) "Orthotic device" means a rigid or semirigid device supporting a weak or deformed leg, foot, arm, hand, back or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back or neck.

(b) "Prosthetic device" means an artificial limb device or appliance designed to replace in whole or in part an arm or a leg.

(3) The Director of the Department of Consumer and Business Services shall adopt and annually update rules listing the prosthetic and orthotic devices covered under this section. The list shall be no more restrictive than the list of prosthetic and orthotic devices and supplies in the Medicare fee schedule for Durable Medical Equipment, Prosthetics, Orthotics and Supplies, but only to the extent consistent with this section.

(4) The coverage required by subsection (1) of this section may be made subject to, and no more restrictive than, the provisions of a health insurance policy that apply to other benefits under the policy.

(5) The coverage required by subsection (1) of this section shall include any repair or replacement of a prosthetic or orthotic device that is determined medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that is not solely for comfort or convenience.

(6) If coverage under subsection (1) of this section is provided through a managed care plan, the insured shall have access to medically necessary clinical care and to prosthetic and orthotic devices and technology from not less than two distinct Oregon prosthetic and orthotic providers in the man-

aged care plan's provider network.

SECTION 5. ORS 743A.148 is amended to read:

743A.148. (1) The Legislative Assembly declares that all group health insurance policies providing hospital, medical or surgical expense benefits**, other than limited benefit coverage,** include coverage for maxillofacial prosthetic services considered necessary for adjunctive treatment.

(2) As used in this section, "maxillofacial prosthetic services considered necessary for adjunctive treatment" means restoration and management of head and facial structures that cannot be replaced with living tissue and that are defective because of disease, trauma or birth and developmental deformities when such restoration and management are performed for the purpose of:

(a) Controlling or eliminating infection;

(b) Controlling or eliminating pain; or

(c) Restoring facial configuration or functions such as speech, swallowing or chewing but not including cosmetic procedures rendered to improve on the normal range of conditions.

(3) The coverage required by subsection (1) of this section may be made subject to provisions of the policy that apply to other benefits under the policy including, but not limited to, provisions relating to deductibles and coinsurance.

(4) The services described in this section shall apply to individual health policies entered into or renewed on or after January 1, 1982.

SECTION 6. ORS 743A.160 is amended to read:

743A.160. A health insurance policy providing coverage for hospital or medical expenses**, other than limited benefit coverage,** [*not limited to expenses from accidents or specified sicknesses*] shall provide, at the request of the applicant, coverage for expenses arising from treatment for alcoholism. The following conditions apply to the requirement for such coverage:

(1) The applicant shall be informed of the applicant's option to request this coverage.

(2) The inclusion of the coverage may be made subject to the insurer's usual underwriting requirements.

(3) The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to deductibles and coinsurance.

(4) The policy may limit hospital expense coverage to treatment provided by the following facilities:

(a) A health care facility licensed as required by ORS 441.015.

(b) A health care facility accredited by the Joint Commission on Accreditation of Hospitals.

(5) Except as permitted by subsection (3) of this section, the policy shall not limit payments thereunder for alcoholism to an amount less than $4,500 in any 24-consecutive month period and the policy shall provide coverage, within the limits of this subsection, of not less than 80 percent of the hospital and medical expenses for treatment for alcoholism.

SECTION 7. ORS 743A.168 is amended to read:

743A.168. A group health insurance policy providing coverage for hospital or medical expenses**, other than limited benefit coverage,** shall provide coverage for expenses arising from treatment for chemical dependency, including alcoholism, and for mental or nervous conditions at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions. The following apply to coverage for chemical dependency and for mental or nervous conditions:

(1) As used in this section:

(a) "Chemical dependency" means the addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with the individual's social, psychological or physical adjustment to common problems. For purposes of this section, "chemical dependency" does not include addiction to, or dependency on, tobacco, tobacco products or foods.

(b) "Facility" means a corporate or governmental entity or other provider of services for the treatment of chemical dependency or for the treatment of mental or nervous conditions.

(c) "Group health insurer" means an insurer, a health maintenance organization or a health care service contractor.

(d) "Program" means a particular type or level of service that is organizationally distinct within a facility.

(e) "Provider" means a person that:

(A) Has met the credentialing requirement of a group health insurer, is otherwise eligible to receive reimbursement for coverage under the policy and is:

(i) A health facility as defined in ORS 430.010;

(ii) A residential facility as defined in ORS 430.010;

(iii) A day or partial hospitalization program as defined in ORS 430.010;

(iv) An outpatient service as defined in ORS 430.010; or

(v) An individual behavioral health or medical professional licensed or certified under Oregon law; or

(B) Is a provider organization certified by the Oregon Health Authority under subsection (13) of this section.

(2) The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to deductibles and coinsurance. Deductibles and coinsurance for treatment in health facilities or residential facilities may not be greater than those under the policy for expenses of hospitalization in the treatment of other medical conditions. Deductibles and coinsurance for outpatient treatment may not be greater than those under the policy for expenses of outpatient treatment of other medical conditions.

(3) The coverage may not be made subject to treatment limitations, limits on total payments for treatment, limits on duration of treatment or financial requirements unless similar limitations or requirements are imposed on coverage of other medical conditions. The coverage of eligible expenses may be

limited to treatment that is medically necessary as determined under the policy for other medical conditions.

(4)(a) Nothing in this section requires coverage for:

(A) Educational or correctional services or sheltered living provided by a school or halfway house;

(B) A long-term residential mental health program that lasts longer than 45 days;

(C) Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present; or

(D) A court-ordered sex offender treatment program.

(b) Notwithstanding paragraph (a)(A) of this subsection, an insured may receive covered outpatient services under the terms of the insured's policy while the insured is living temporarily in a sheltered living situation.

(5) A provider is eligible for reimbursement under this section if:

(a) The provider is approved or certified by the Oregon Health Authority;

(b) The provider is accredited for the particular level of care for which reimbursement is being requested by the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation of Rehabilitation Facilities;

(c) The patient is staying overnight at the facility and is involved in a structured program at least eight hours per day, five days per week; or

(d) The provider is providing a covered benefit under the policy.

(6) Payments may not be made under this section for support groups.

(7) If specified in the policy, outpatient coverage may include follow-up in-home service or outpatient services. The policy may limit coverage for in-home service to persons who are homebound under the care of a physician.

(8) Nothing in this section prohibits a group health insurer from managing the provision of benefits through common methods, including but not limited to selectively contracted panels, health plan benefit differential designs, preadmission screening, prior authorization of services, utilization review or other mechanisms designed to limit eligible expenses to those

described in subsection (3) of this section.

(9) The Legislative Assembly has found that health care cost containment is necessary and intends to encourage insurance policies designed to achieve cost containment by ensuring that reimbursement is limited to appropriate utilization under criteria incorporated into such policies, either directly or by reference.

(10)(a) Subject to the patient or client confidentiality provisions of ORS 40.235 relating to physicians, ORS 40.240 relating to nurse practitioners, ORS 40.230 relating to psychologists, ORS 40.250 and 675.580 relating to licensed clinical social workers and ORS 40.262 relating to licensed professional counselors and licensed marriage and family therapists, a group health insurer may provide for review for level of treatment of admissions and continued stays for treatment in health facilities, residential facilities, day or partial hospitalization programs and outpatient services by either group health insurer staff or personnel under contract to the group health insurer, or by a utilization review contractor, who shall have the authority to certify for or deny level of payment.

(b) Review shall be made according to criteria made available to providers in advance upon request.

(c) Review shall be performed by or under the direction of a medical or osteopathic physician licensed by the Oregon Medical Board, a psychologist licensed by the State Board of Psychologist Examiners, a clinical social worker licensed by the State Board of Licensed Social Workers or a professional counselor or marriage and family therapist licensed by the Oregon Board of Licensed Professional Counselors and Therapists, in accordance with standards of the National Committee for Quality Assurance or Medicare review standards of the Centers for Medicare and Medicaid Services.

(d) Review may involve prior approval, concurrent review of the continuation of treatment, post-treatment review or any combination of these. However, if prior approval is required, provision shall be made to allow for payment of urgent or emergency admissions, subject to subsequent review.

If prior approval is not required, group health insurers shall permit providers, policyholders or persons acting on their behalf to make advance inquiries regarding the appropriateness of a particular admission to a treatment program. Group health insurers shall provide a timely response to such inquiries. Noncontracting providers must cooperate with these procedures to the same extent as contracting providers to be eligible for reimbursement.

(11) Health maintenance organizations may limit the receipt of covered services by enrollees to services provided by or upon referral by providers contracting with the health maintenance organization. Health maintenance organizations and health care service contractors may create substantive plan benefit and reimbursement differentials at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising out of other medical conditions and apply them to contracting and noncontracting providers.

(12) Nothing in this section prevents a group health insurer from contracting with providers of health care services to furnish services to policyholders or certificate holders according to ORS 743B.460 or 750.005, subject to the following conditions:

(a) A group health insurer is not required to contract with all providers that are eligible for reimbursement under this section.

(b) An insurer or health care service contractor shall, subject to subsections (2) and (3) of this section, pay benefits toward the covered charges of noncontracting providers of services for the treatment of chemical dependency or mental or nervous conditions. The insured shall, subject to subsections (2) and (3) of this section, have the right to use the services of a noncontracting provider of services for the treatment of chemical dependency or mental or nervous conditions, whether or not the services for chemical dependency or mental or nervous conditions are provided by contracting or noncontracting providers.

(13) The Oregon Health Authority shall establish a process for the certi-

fication of an organization described in subsection (1)(e)(B) of this section that:

(a) Is not otherwise subject to licensing or certification by the authority; and

(b) Does not contract with the authority, a subcontractor of the authority or a community mental health program.

(14) The Oregon Health Authority shall adopt by rule standards for the certification provided under subsection (13) of this section to ensure that a certified provider organization offers a distinct and specialized program for the treatment of mental or nervous conditions.

(15) The Oregon Health Authority may adopt by rule an application fee or a certification fee, or both, to be imposed on any provider organization that applies for certification under subsection (13) of this section. Any fees collected shall be paid into the Oregon Health Authority Fund established in ORS 413.101 and shall be used only for carrying out the provisions of subsection (13) of this section.

(16) The intent of the Legislative Assembly in adopting this section is to reserve benefits for different types of care to encourage cost effective care and to ensure continuing access to levels of care most appropriate for the insured's condition and progress. This section does not prohibit an insurer from requiring a provider organization certified by the Oregon Health Authority under subsection (13) of this section to meet the insurer's credentialing requirements as a condition of entering into a contract.

(17) The Director of the Department of Consumer and Business Services and the Oregon Health Authority, after notice and hearing, may adopt reasonable rules not inconsistent with this section that are considered necessary for the proper administration of this section.

SECTION 8. The amendments to ORS 743A.148 and 743A.168 by sections 5 and 7 of this 2016 Act apply to policies and certificates of health insurance issued or renewed on or after the effective date of this 2016 Act.

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