# Chapter 743B

**2015 EDITION**

# Health Benefit Plans: Individual and Group

## DEFINITIONS AND PURPOSES

**743B.001 Definitions.** As used in this section and ORS 743.008, 743.035, 743B.195, 743B.197, 743B.200, 743B.202, 743B.204, 743B.206, 743B.220, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.310, 743B.400, 743B.403, 743B.405, 743B.420, 743B.422, 743B.423, 743B.424, 743B.450, 743B.451, 743B.452, 743B.453, 743B.454, 743B.550 and 743B.555:

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

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

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

(c) Imposition of a preexisting condition exclusion as defined in ORS 743B.005, source-of-injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or services;

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

(e) Determination that a course or plan of treatment that an enrollee is undergoing is an active course of treatment for purposes of continuity of care under ORS 743B.225.

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

(3) "Credit card" has the meaning given that term in 15 U.S.C. 1602.

(4) "Electronic funds transfer" has the meaning given that term in ORS 293.525.

(5) "Enrollee" has the meaning given that term in ORS 743B.005.

(6) "Grievance" means:

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

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

(B) In writing or orally, for an expedited response described in ORS 743B.250 (2)(d) or an expedited external review; or

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

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

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

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

(7) "Health benefit plan" has the meaning given that term in ORS 743B.005.

(8) "Independent practice association" means a corporation wholly owned by providers, or whose membership consists entirely of providers, formed for the sole purpose of contracting with insurers for the provision of health care services to enrollees, or with employers for the provision of health care services to employees, or with a group, as described in ORS 731.098, to provide health care services to group members.

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

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

(11) "Managed health insurance" means any health benefit plan that:

(a) Requires an enrollee to use a specified network or networks of providers managed, owned, under contract with or employed by the insurer in order to receive benefits under the plan, except for emergency or other specified limited service; or

(b) In addition to the requirements of paragraph (a) of this subsection, offers a point-of-service provision that allows an enrollee to use providers outside of the specified network or networks at the option of the enrollee and receive a reduced level of benefits.

(12) "Medical services contract" means a contract between an insurer and an independent practice association, between an insurer and a provider, between an independent practice association and a provider or organization of providers, between medical or mental health clinics, and between a medical or mental health clinic and a provider to provide medical or mental health services. "Medical services contract" does not include a contract of employment or a contract creating legal entities and ownership thereof that are authorized under ORS chapter 58, 60 or 70, or other similar professional organizations permitted by statute.

(13)(a) "Preferred provider organization insurance" means any health benefit plan that:

(A) Specifies a preferred network of providers managed, owned or under contract with or employed by an insurer;

(B) Does not require an enrollee to use the preferred network of providers in order to receive benefits under the plan; and

(C) Creates financial incentives for an enrollee to use the preferred network of providers by providing an increased level of benefits.

(b) "Preferred provider organization insurance" does not mean a health benefit plan that has as its sole financial incentive a hold harmless provision under which providers in the preferred network agree to accept as payment in full the maximum allowable amounts that are specified in the medical services contracts.

(14) "Prior authorization" means a determination by an insurer prior to provision of services that the insurer will provide reimbursement for the services. "Prior authorization" does not include referral approval for evaluation and management services between providers.

(15)(a) "Provider" means a person licensed, certified or otherwise authorized or permitted by laws of this state to administer medical or mental health services in the ordinary course of business or practice of a profession.

(b) With respect to the statutes governing the billing for or payment of claims, "provider" also includes an employee or other designee of the provider who has the responsibility for billing claims for reimbursement or receiving payments on claims.

(16) "Utilization review" means a set of formal techniques used by an insurer or delegated by the insurer designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services, procedures or settings. [Formerly 743.801]

**Note:** The amendments to 743B.001 (formerly 743.801) by sections 3 and 4, chapter 59, Oregon Laws 2015, become operative January 1, 2017, and apply to health benefit plans in effect on or after January 1, 2017. See section 11, chapter 59, Oregon Laws 2015. The text that is operative on and after January 1, 2017, is set forth for the user's convenience.

**743B.001.** As used in this section and ORS 743.008, 743.035, 743B.195, 743B.197, 743B.200, 743B.202, 743B.204, 743B.206, 743B.220, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.310, 743B.400, 743B.403, 743B.405, 743B.420, 743B.422, 743B.423, 743B.424, 743B.450, 743B.451, 743B.452, 743B.453, 743B.454, 743B.505, 743B.550 and 743B.555:

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

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

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

(c) Imposition of a preexisting condition exclusion as defined in ORS 743B.005, source-of-injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or services;

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

(e) Determination that a course or plan of treatment that an enrollee is undergoing is an active course of treatment for purposes of continuity of care under ORS 743B.225.

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

(3) "Credit card" has the meaning given that term in 15 U.S.C. 1602.

(4) "Electronic funds transfer" has the meaning given that term in ORS 293.525.

(5) "Enrollee" has the meaning given that term in ORS 743B.005.

(6) "Essential community provider" has the meaning given that term in rules adopted by the Department of Consumer and Business Services consistent with the description of the term in 42 U.S.C. 18031 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. 18031.

(7) "Grievance" means:

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

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

(B) In writing or orally, for an expedited response described in ORS 743B.250 (2)(d) or an expedited external review; or

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

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

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

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

(8) "Health benefit plan" has the meaning given that term in ORS 743B.005.

(9) "Independent practice association" means a corporation wholly owned by providers, or whose membership consists entirely of providers, formed for the sole purpose of contracting with insurers for the provision of health care services to enrollees, or with employers for the provision of health care services to employees, or with a group, as described in ORS 731.098, to provide health care services to group members.

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

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

(12) "Managed health insurance" means any health benefit plan that:

(a) Requires an enrollee to use a specified network or networks of providers managed, owned, under contract with or employed by the insurer in order to receive benefits under the plan, except for emergency or other specified limited service; or

(b) In addition to the requirements of paragraph (a) of this subsection, offers a point-of-service provision that allows an enrollee to use providers outside of the specified network or networks at the option of the enrollee and receive a reduced level of benefits.

(13) "Medical services contract" means a contract between an insurer and an independent practice association, between an insurer and a provider, between an independent practice association and a provider or organization of providers, between medical or mental health clinics, and between a medical or mental health clinic and a provider to provide medical or mental health services. "Medical services contract" does not include a contract of employment or a contract creating legal entities and ownership thereof that are authorized under ORS chapter 58, 60 or 70, or other similar professional organizations permitted by statute.

(14)(a) "Preferred provider organization insurance" means any health benefit plan that:

(A) Specifies a preferred network of providers managed, owned or under contract with or employed by an insurer;

(B) Does not require an enrollee to use the preferred network of providers in order to receive benefits under the plan; and

(C) Creates financial incentives for an enrollee to use the preferred network of providers by providing an increased level of benefits.

(b) "Preferred provider organization insurance" does not mean a health benefit plan that has as its sole financial incentive a hold harmless provision under which providers in the preferred network agree to accept as payment in full the maximum allowable amounts that are specified in the medical services contracts.

(15) "Prior authorization" means a determination by an insurer prior to provision of services that the insurer will provide reimbursement for the services. "Prior authorization" does not include referral approval for evaluation and management services between providers.

(16)(a) "Provider" means a person licensed, certified or otherwise authorized or permitted by laws of this state to administer medical or mental health services in the ordinary course of business or practice of a profession.

(b) With respect to the statutes governing the billing for or payment of claims, "provider" also includes an employee or other designee of the provider who has the responsibility for billing claims for reimbursement or receiving payments on claims.

(17) "Utilization review" means a set of formal techniques used by an insurer or delegated by the insurer designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services, procedures or settings.

**743B.003 Purposes.** The purposes of ORS 743.004, 743.022, 743.535, 743B.003 to 743B.127 and 743B.800 are:

(1) To promote the availability of health insurance coverage to groups regardless of their enrollees' health status or claims experience;

(2) To prevent abusive rating practices;

(3) To require disclosure of rating practices to purchasers of small employer and individual health benefit plans;

(4) To prohibit the use of preexisting condition exclusions except in individual grandfathered health plans;

(5) To encourage the availability of individual health benefit plans for individuals who are not enrolled in group health benefit plans;

(6) To improve renewability and continuity of coverage for employers and covered individuals;

(7) To improve the efficiency and fairness of the health insurance marketplace; and

(8) To ensure that health insurance coverage in Oregon satisfies the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) and the Patient Protection and Affordable Care Act (P.L. 111-148) as amended by the Health Care and Education Reconciliation Act (P.L. 111-152), and that enforcement authority for those requirements is retained by the Director of the Department of Consumer and Business Services. [Formerly 743.731]

**743B.005 Definitions.** For purposes of ORS 743.004, 743.007, 743.022, 743.535, 743B.003 to 743B.127 and 743B.128:

(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Director of the Department of Consumer and Business Services that a carrier is in compliance with the provisions of ORS 743B.012 based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the carrier in establishing premium rates for small employer health benefit plans.

(2) "Affiliate" of, or person "affiliated" with, a specified person means any carrier who, directly or indirectly through one or more intermediaries, controls or is controlled by or is under common control with a specified person. For purposes of this definition, "control" has the meaning given that term in ORS 732.548.

(3) "Affiliation period" means, under the terms of a group health benefit plan issued by a health care service contractor, a period:

(a) That is applied uniformly and without regard to any health status related factors to an enrollee or late enrollee;

(b) That must expire before any coverage becomes effective under the plan for the enrollee or late enrollee;

(c) During which no premium shall be charged to the enrollee or late enrollee; and

(d) That begins on the enrollee's or late enrollee's first date of eligibility for coverage and runs concurrently with any eligibility waiting period under the plan.

(4) "Bona fide association" means an association that:

(a) Has been in active existence for at least five years;

(b) Has been formed and maintained in good faith for purposes other than obtaining insurance;

(c) Does not condition membership in the association on any factor relating to the health status of an individual or the individual's dependent or employee;

(d) Makes health insurance coverage that is offered through the association available to all members of the association regardless of the health status of the member or individuals who are eligible for coverage through the member;

(e) Does not make health insurance coverage that is offered through the association available other than in connection with a member of the association;

(f) Has a constitution and bylaws; and

(g) Is not owned or controlled by a carrier, producer or affiliate of a carrier or producer.

(5) "Carrier" means any person who provides health benefit plans in this state, including:

(a) A licensed insurance company;

(b) A health care service contractor;

(c) A health maintenance organization;

(d) An association or group of employers that provides benefits by means of a multiple employer welfare arrangement and that:

(A) Is subject to ORS 750.301 to 750.341; or

(B) Is fully insured and otherwise exempt under ORS 750.303 (4) but elects to be governed by ORS 743B.010 to 743B.013; or

(e) Any other person or corporation responsible for the payment of benefits or provision of services.

(6) "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health benefit plan covering the employee.

(7) "Eligible employee" means an employee who is eligible for coverage under a group health benefit plan.

(8) "Employee" means any individual employed by an employer.

(9) "Enrollee" means an employee, dependent of the employee or an individual otherwise eligible for a group or individual health benefit plan who has enrolled for coverage under the terms of the plan.

(10) "Exchange" means an American Health Benefit Exchange described in 42 U.S.C. 18031, 18032, 18033 and 18041.

(11) "Exclusion period" means a period during which specified treatments or services are excluded from coverage.

(12) "Financial impairment" means that a carrier is not insolvent and is:

(a) Considered by the director to be potentially unable to fulfill its contractual obligations; or

(b) Placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(13)(a) "Geographic average rate" means the arithmetical average of the lowest premium and the corresponding highest premium to be charged by a carrier in a geographic area established by the director for the carrier's:

(A) Group health benefit plans offered to small employers; or

(B) Individual health benefit plans.

(b) "Geographic average rate" does not include premium differences that are due to differences in benefit design, age, tobacco use or family composition.

(14) "Grandfathered health plan" has the meaning prescribed by the United States Secretaries of Labor, Health and Human Services and the Treasury pursuant to 42 U.S.C. 18011(e).

(15) "Group eligibility waiting period" means, with respect to a group health benefit plan, the period of employment or membership with the group that a prospective enrollee must complete before plan coverage begins.

(16)(a) "Health benefit plan" means any:

(A) Hospital expense, medical expense or hospital or medical expense policy or certificate;

(B) Subscriber contract of a health care service contractor as defined in ORS 750.005; or

(C) Plan provided by a multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended, to the extent that the plan is subject to state regulation.

(b) "Health benefit plan" does not include:

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

(B) Coverage of Medicare services pursuant to contracts with the federal government;

(C) Medicare supplement insurance policies;

(D) Coverage of TRICARE services pursuant to contracts with the federal government;

(E) Benefits delivered through a flexible spending arrangement established pursuant to section 125 of the Internal Revenue Code of 1986, as amended, when the benefits are provided in addition to a group health benefit plan;

(F) Separately offered long term care insurance, including, but not limited to, coverage of nursing home care, home health care and community-based care;

(G) Independent, noncoordinated, hospital-only indemnity insurance or other fixed indemnity insurance;

(H) Short term health insurance policies that are in effect for periods of 12 months or less, including the term of a renewal of the policy;

(I) Dental only coverage;

(J) Vision only coverage;

(K) Stop-loss coverage that meets the requirements of ORS 742.065;

(L) Coverage issued as a supplement to liability insurance;

(M) Insurance arising out of a workers' compensation or similar law;

(N) Automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance; or

(O) Any employee welfare benefit plan that is exempt from state regulation because of the federal Employee Retirement Income Security Act of 1974, as amended.

(c) For purposes of this subsection, renewal of a short term health insurance policy includes the issuance of a new short term health insurance policy by an insurer to a policyholder within 60 days after the expiration of a policy previously issued by the insurer to the policyholder.

(17) "Individual health benefit plan" means a health benefit plan:

(a) That is issued to an individual policyholder; or

(b) That provides individual coverage through a trust, association or similar group, regardless of the situs of the policy or contract.

(18) "Initial enrollment period" means a period of at least 30 days following commencement of the first eligibility period for an individual.

(19) "Late enrollee" means an individual who enrolls in a group health benefit plan subsequent to the initial enrollment period during which the individual was eligible for coverage but declined to enroll. However, an eligible individual shall not be considered a late enrollee if:

(a) The individual qualifies for a special enrollment period in accordance with 42 U.S.C. 300gg or as prescribed by rule by the Department of Consumer and Business Services;

(b) The individual applies for coverage during an open enrollment period;

(c) A court issues an order that coverage be provided for a spouse or minor child under an employee's employer sponsored health benefit plan and request for enrollment is made within 30 days after issuance of the court order;

(d) The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period; or

(e) The individual's coverage under Medicaid, Medicare, TRICARE, Indian Health Service or a publicly sponsored or subsidized health plan, including, but not limited to, the medical assistance program under ORS chapter 414, has been involuntarily terminated within 63 days after applying for coverage in a group health benefit plan.

(20) "Multiple employer welfare arrangement" means a multiple employer welfare arrangement as defined in section 3 of the federal Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. 1002, that is subject to ORS 750.301 to 750.341.

(21) "Preexisting condition exclusion" means:

(a) Except for a grandfathered health plan, a limitation or exclusion of benefits or a denial of coverage based on a medical condition being present before the effective date of coverage or before the date coverage is denied, whether or not any medical advice, diagnosis, care or treatment was recommended or received for the condition before the date of coverage or denial of coverage.

(b) With respect to a grandfathered health plan, a provision applicable to an enrollee or late enrollee that excludes coverage for services, charges or expenses incurred during a specified period immediately

following enrollment for a condition for which medical advice, diagnosis, care or treatment was recommended or received during a specified period immediately preceding enrollment. For purposes of this paragraph pregnancy and genetic information do not constitute preexisting conditions.

(22) "Premium" includes insurance premiums or other fees charged for a health benefit plan, including the costs of benefits paid or reimbursements made to or on behalf of enrollees covered by the plan.

(23) "Rating period" means the 12-month calendar period for which premium rates established by a carrier are in effect, as determined by the carrier.

(24) "Representative" does not include an insurance producer or an employee or authorized representative of an insurance producer or carrier.

(25) "Small employer" has the meaning given that term in 42 U.S.C. 18024 unless otherwise prescribed by the department by rule in accordance with guidance issued by the United States Department of Health and Human Services, the United States Department of Labor or the United States Department of the Treasury. [Formerly 743.730]

## EMPLOYER-SPONSORED HEALTH INSURANCE

**743B.010 Issuance of group health benefit plan to affiliated group of employers; determination of number of employees for purpose of determining eligibility as small employer.** (1) If an affiliated group of employers is treated as a single employer under section 414 (b), (c), (m) or (o) of the Internal Revenue Code of 1986, a carrier may issue a single group health benefit plan to the affiliated group on the basis of the number of employees in the affiliated group if the group requests such coverage.

(2) Subsequent to the issuance of a health benefit plan to a small employer, other than a plan issued through the health insurance exchange, a carrier shall determine annually the number of employees of the employer for purposes of determining the employer's ongoing eligibility as a small employer.

(3)(a) ORS 743B.010 to 743B.013 shall continue to apply to a health benefit plan issued outside of the exchange to a small employer until the plan anniversary date following the date the employer no longer meets the definition of a small employer.

(b) ORS 743B.010 to 743B.013 shall continue to apply to an employer that receives coverage through the exchange until the employer no longer receives coverage through the exchange and is no longer a small employer. [Formerly 743.733]

**743B.011 Group health benefit plans subject to provisions of specified laws; exemptions.** (1) Every health benefit plan shall be subject to the provisions of ORS 743B.010 to 743B.013, if the plan provides health benefits covering one or more employees of a small employer and if any one of the following conditions is met:

(a) Any portion of the premium or benefits is paid by a small employer or any employee is reimbursed, whether through wage adjustments or otherwise, by a small employer for any portion of the health benefit plan premium; or

(b) The health benefit plan is treated by the employer or any of the employees as part of a plan or program for the purposes of section 106, section 125 or section 162 of the Internal Revenue Code of 1986, as amended.

(2) Except as otherwise provided by ORS 743B.010 to 743B.013 or other law, no health benefit plan offered to a small employer shall:

(a) Inhibit a carrier from contracting with providers or groups of providers with respect to health care services or benefits; or

(b) Impose any restriction on the ability of a carrier to negotiate with providers regarding the level or method of reimbursing care or services provided under health benefit plans.

(3)(a) A carrier may provide different health benefit plans to different categories of employees of a small employer when the employer has chosen to establish different categories of employees in a manner that does not relate to the actual or expected health status of such employees or their dependents. The categories must be based on bona fide employment-based classifications that are consistent with the employer's usual business practice.

(b) Except as provided in ORS 743B.012 (7), a carrier that offers coverage to a small employer shall offer coverage to all eligible employees of the small employer.

(c) If a small employer elects to offer coverage to dependents of eligible employees, the carrier shall offer coverage to all dependents of eligible employees.

(4) An insurer may not deny, delay or terminate participation of an individual in a group health benefit plan or exclude coverage otherwise provided to an individual under a group health benefit plan based on a preexisting condition of the individual. [Formerly 743.734]

**743B.012 Requirement to offer all health benefit plans to small employers; offering of plan by carriers; exceptions.** (1) As a condition of transacting business in the small employer health insurance market in this state, a carrier shall offer small employers all of the carrier's health benefit plans, approved by the Department of Consumer and Business Services for use in the small employer market, for which the small employer is eligible.

(2) A carrier shall issue to a small employer any health benefit plan that is offered by the carrier if the small employer applies for the plan and agrees to make the required premium payments and to satisfy the other provisions of the health benefit plan.

(3) A multiple employer welfare arrangement, professional or trade association or other similar arrangement established or maintained to provide benefits to a particular trade, business, profession or industry or their subsidiaries may not issue coverage to a group or individual that is not in the same trade, business, profession or industry as that covered by the arrangement. The arrangement shall accept all groups and individuals in the same trade, business, profession or industry or their subsidiaries that apply for coverage under the arrangement and that meet the requirements for membership in the arrangement. For purposes of this subsection, the requirements for membership in an arrangement may not include any requirements that relate to the actual or expected health status of the prospective enrollee.

(4) A carrier shall, pursuant to subsection (2) of this section, accept applications from and offer coverage to a small employer group covered under an existing health benefit plan regardless of whether a prospective enrollee is excluded from coverage under the existing plan because of late enrollment. When a carrier accepts an application for a small employer group, the carrier may continue to exclude the prospective enrollee excluded from coverage by the replaced plan until the prospective enrollee would have become eligible for coverage under that replaced plan.

(5) A carrier is not required to accept applications from and offer coverage pursuant to subsection (2) of this section if the department finds that acceptance of an application or applications would endanger the carrier's ability to fulfill its contractual obligations or result in financial impairment of the carrier.

(6) A carrier shall actively market all health benefit plans that are offered by the carrier to small employers in the geographical areas in which the carrier makes coverage available or provides benefits.

(7)(a) Subsection (2) of this section does not require a carrier to offer coverage to or accept applications from:

(A) A small employer if the small employer is not physically located in the carrier's approved service area;

(B) An employee of a small employer if the employee does not work or reside within the carrier's approved service areas; or

(C) Small employers located within an area where the carrier reasonably anticipates, and demonstrates to the department, that it will not have the capacity in its network of providers to deliver services adequately to the enrollees of those small employer groups because of its obligations to existing small employer group contract holders and enrollees.

(b) A carrier that does not offer coverage pursuant to paragraph (a)(C) of this subsection may not offer coverage in the applicable service area to new employer groups other than small employers until the carrier resumes enrolling groups of new small employers in the applicable area.

(8) For purposes of ORS 743B.010 to 743B.013, except as provided in this subsection, carriers that are affiliated carriers or that are eligible to file a consolidated tax return pursuant to ORS 317.715 shall be treated as one carrier and any restrictions or limitations imposed by ORS 743B.010 to 743B.013 apply as if all health benefit plans delivered or issued for delivery to small employers in this state by the affiliated carriers were issued by one carrier. However, any insurance company or health maintenance organization that is an affiliate of a health care service contractor located in this state, or any health maintenance organization located in this state that is an affiliate of an insurance company or health care service contractor, may treat the health maintenance organization as a separate carrier and each health maintenance organization that operates only one health maintenance organization in a service area in this state may be considered a separate carrier.

(9) A carrier that elects to discontinue offering all of its health benefit plans to small employers under ORS 743B.013 (3)(e) or elects to discontinue renewing all such plans is prohibited from offering health benefit plans to small employers in this state for a period of five years from one of the following dates:

(a) The date of notice to the department pursuant to ORS 743B.013 (3)(e); or

(b) If notice is not provided under paragraph (a) of this subsection, from the date on which the department provides notice to the carrier that the department has determined

that the carrier has effectively discontinued offering health benefit plans to small employers in this state. [Formerly 743.736]

**743B.013 Requirements for small employer health benefit plans.** (1) A health benefit plan issued to a small employer:

(a) Other than a grandfathered health plan, must cover essential health benefits consistent with 42 U.S.C. 300gg-11.

(b) May require an affiliation period that does not exceed two months for an enrollee or 90 days for a late enrollee.

(c) May not apply a preexisting condition exclusion to any enrollee.

(2) Late enrollees in a small employer health benefit plan may be subjected to a group eligibility waiting period that does not exceed 90 days.

(3) Each small employer health benefit plan shall be renewable with respect to all eligible enrollees at the option of the policyholder, small employer or contract holder unless:

(a) The policyholder, small employer or contract holder fails to pay the required premiums.

(b) The policyholder, small employer or contract holder or, with respect to coverage of individual enrollees, an enrollee or a representative of an enrollee engages in fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan.

(c) The number of enrollees covered under the plan is less than the number or percentage of enrollees required by participation requirements under the plan.

(d) The small employer fails to comply with the contribution requirements under the health benefit plan.

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

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

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

(C) May not cancel coverage under the plans for 90 days after the date of the notice required under subparagraph (A) of this paragraph if coverage is discontinued in a specified service area because of an inability to reach an agreement with the health care providers or organization of health care providers to provide services under the plans within the service area.

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

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

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

(C) Must offer in writing to each small employer covered by the plan, all other small employer health benefit plans that the carrier offers to small employers in the specified service area. The carrier shall issue any such plans pursuant to the provisions of ORS 743B.010 to 743B.013. The carrier shall offer the plans at least 90 days prior to discontinuation.

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

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

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

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

(B) Issue any such plans pursuant to the provisions of ORS 743B.010 to 743B.013.

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

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

(j) The Director of the Department of Consumer and Business Services orders the carrier to discontinue coverage in accor-

dance with procedures specified or approved by the director upon finding that the continuation of the coverage would:

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

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

(k) In the case of a small employer health benefit plan that delivers covered services through a specified network of health care providers, there is no longer any enrollee who lives, resides or works in the service area of the provider network.

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

(4) A carrier may modify a small employer health benefit plan at the time of coverage renewal. The modification is not a discontinuation of the plan under subsection (3)(e), (g) and (h) of this section.

(5) Notwithstanding any provision of subsection (3) of this section to the contrary, a carrier may not rescind the coverage of an enrollee in a small employer health benefit plan unless:

(a) The enrollee or a person seeking coverage on behalf of the enrollee:

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

(B) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan;

(b) The carrier provides at least 30 days' advance written notice, in the form and manner prescribed by the department, to the enrollee; and

(c) The carrier provides notice of the rescission to the department in the form, manner and time frame prescribed by the department by rule.

(6) Notwithstanding any provision of subsection (3) of this section to the contrary, a carrier may not rescind a small employer health benefit plan unless:

(a) The small employer or a representative of the small employer:

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

(B) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan;

(b) The carrier provides at least 30 days' advance written notice, in the form and manner prescribed by the department, to each plan enrollee who would be affected by the rescission of coverage; and

(c) The carrier provides notice of the rescission to the department in the form, manner and time frame prescribed by the department by rule.

(7)(a) A carrier may continue to enforce reasonable employer participation and contribution requirements on small employers. However, participation and contribution requirements shall be applied uniformly among all small employer groups with the same number of eligible employees applying for coverage or receiving coverage from the carrier. In determining minimum participation requirements, a carrier shall count only those employees who are not covered by an existing group health benefit plan, Medicaid, Medicare, TRICARE, Indian Health Service or a publicly sponsored or subsidized health plan, including but not limited to the medical assistance program under ORS chapter 414.

(b) A carrier may not deny a small employer's application for coverage under a health benefit plan based on participation or contribution requirements but may require small employers that do not meet participation or contribution requirements to enroll during the open enrollment period beginning November 15 and ending December 15.

(8) Premium rates for small employer health benefit plans, except grandfathered health plans, shall be subject to the following provisions:

(a) Each carrier must file with the department the initial geographic average rate and any changes in the geographic average rate with respect to each health benefit plan issued by the carrier to small employers.

(b)(A) The variations in premium rates charged during a rating period for health benefit plans issued to small employers shall be based solely on the factors specified in subparagraph (B) of this paragraph. A carrier may elect which of the factors specified in subparagraph (B) of this paragraph apply to premium rates for health benefit plans for small employers. All other factors must be applied in the same actuarially sound way to all small employer health benefit plans.

(B) The variations in premium rates described in subparagraph (A) of this paragraph may be based only on one or more of the following factors as prescribed by the department by rule:

(i) The ages of enrolled employees and their dependents, except that the rate for adults may not vary by more than three to one;

(ii) The level at which enrolled employees and their dependents 18 years of age and

older engage in tobacco use, except that the rate may not vary by more than 1.5 to one; and

(iii) Adjustments to reflect differences in family composition.

(C) A carrier shall apply the carrier's schedule of premium rate variations as approved by the department and in accordance with this paragraph. Except as otherwise provided in this section, the premium rate established by a carrier for a small employer health benefit plan shall apply uniformly to all employees of the small employer enrolled in that plan.

(c) Except as provided in paragraph (b) of this subsection, the variation in premium rates between different health benefit plans offered by a carrier to small employers must be based solely on objective differences in plan design or coverage, age, tobacco use and family composition and must not include differences based on the risk characteristics of groups assumed to select a particular health benefit plan.

(d) A carrier may not increase the rates of a health benefit plan issued to a small employer more than once in a 12-month period. Annual rate increases shall be effective on the plan anniversary date of the health benefit plan issued to a small employer. The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(A) The percentage change in the geographic average rate measured from the first day of the prior rating period to the first day of the new period; and

(B) Any adjustment attributable to changes in age and differences in family composition.

(9) Premium rates for grandfathered health plans shall be subject to requirements prescribed by the department by rule.

(10) In connection with the offering for sale of any health benefit plan to a small employer, each carrier shall make a reasonable disclosure as part of its solicitation and sales materials of:

(a) The full array of health benefit plans that are offered to small employers by the carrier;

(b) The authority of the carrier to adjust rates and premiums, and the extent to which the carrier considers age, tobacco use, family composition and geographic factors in establishing and adjusting rates and premiums; and

(c) The benefits and premiums for all health insurance coverage for which the employer is qualified.

(11)(a) Each carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices relating to its small employer health benefit plans, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial practices and are in accordance with sound actuarial principles.

(b) A carrier offering a small employer health benefit plan shall file with the department at least once every 12 months an actuarial certification that the carrier is in compliance with ORS 743B.010 to 743B.013 and that the rating methods of the carrier are actuarially sound. Each certification shall be in a uniform form and manner and shall contain such information as specified by the department. A copy of each certification shall be retained by the carrier at its principal place of business. A carrier is not required to file the actuarial certification under this paragraph if the department has approved the carrier's rate filing within the preceding 12-month period.

(c) A carrier shall make the information and documentation described in paragraph (a) of this subsection available to the department upon request. Except as provided in ORS 743.018 and except in cases of violations of ORS 743B.010 to 743B.013, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure to persons outside the department except as agreed to by the carrier or as ordered by a court of competent jurisdiction.

(12) A carrier shall not provide any financial or other incentive to any insurance producer that would encourage the insurance producer to sell health benefit plans of the carrier to small employer groups based on a small employer group's anticipated claims experience.

(13) For purposes of this section, the date a small employer health benefit plan is continued shall be the anniversary date of the first issuance of the health benefit plan.

(14) A carrier must include a provision that offers coverage to all eligible employees of a small employer and to all dependents of the eligible employees to the extent the employer chooses to offer coverage to dependents.

(15) All small employer health benefit plans shall contain special enrollment periods during which eligible employees and dependents may enroll for coverage, as provided by federal law and rules adopted by the department.

(16) A small employer health benefit plan may not impose annual or lifetime limits on

the dollar amount of essential health benefits. [Formerly 743.737]

**743B.020 Eligible employees and small employers; rules.** (1) The Department of Consumer and Business Services shall adopt by rule a method for determining whether:

(a) An employee is an eligible employee as defined in ORS 743B.005; and

(b) An employer is a small employer as defined in ORS 743B.005.

(2) The method adopted by the department under subsection (1) of this section must be consistent with corresponding federal requirements for the Small Business Health Options Program as defined in ORS 741.300. [2015 c.515 §3a]

**Note:** 743B.020 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743B or any series therein. See Preface to Oregon Revised Statutes for further explanation.

## MARKETING REQUIREMENTS

**743B.100 Department's authority to regulate market.** (1) In order to ensure the broadest availability of small employer and individual health benefit plans, the Department of Consumer and Business Services may approve market conduct and other requirements for carriers and insurance producers, including:

(a) Registration by each carrier with the department of the carrier's intention to offer group health benefit plans under ORS 743B.010 to 743B.013 or individual health benefit plans, or both.

(b) To the extent deemed necessary by the department to ensure the fair distribution of high-risk individuals and groups among carriers, periodic reports by carriers and insurance producers concerning small employer and individual health benefit plans issued, provided that reporting requirements shall be limited to information concerning case characteristics and numbers of health benefit plans in various categories sold or issued to small employers and individuals.

(c) Methods concerning periodic demonstration by carriers offering health benefit plans to individuals or small employers and insurance producers that the carriers and insurance producers are selling or issuing health benefit plans in fulfillment of the purposes of ORS 743.004, 743.022, 743.535 and 743B.003 to 743B.127.

(2) The department may require carriers and insurance producers offering health benefit plans to individuals or small employers to use the open and special enrollment periods prescribed by the department by rule. [Formerly 743.745]

**Note:** Sections 5 and 6, chapter 80, Oregon Laws 2014, provide:

**Sec. 5.** (1) As used in this section:

(a) "Health benefit plan" has the meaning given that term in ORS 743.730 [renumbered 743B.005].

(b) "Transitional health benefit plan" means a health benefit plan that:

(A) Was issued to an individual or a small employer who elected to renew coverage under the plan in calendar year 2013 instead of obtaining coverage under a new health benefit plan;

(B) Is in force on the effective date of this 2014 Act [March 19, 2014];

(C) Does not comply with the requirements of the Insurance Code in effect on or after January 1, 2014; and

(D) Complies with the requirements of the Insurance Code in effect on December 31, 2013.

(2) If authorized by guidance from the United States Department of Health and Human Services, the United States Department of Labor or the United States Department of the Treasury, the Department of Consumer and Business Services shall permit a transitional health benefit plan to remain in force until the later of:

(a) December 31, 2015; or

(b) A later date specified by the Department of Consumer and Business Services by rule. [2014 c.80 §5]

**Sec. 6.** Section 5 of this 2014 Act is repealed January 2, 2017. [2014 c.80 §6]

**743B.102 Certifications and disclosure of coverage.** All carriers that offer individual or group health benefit plans shall provide certifications and disclosure of coverage in accordance with 42 U.S.C. 300gg(e) and 300gg-43 as amended and in effect on July 1, 1997. [Formerly 743.749]

**743B.103 Use of health-related information.** (1) Except as provided in subsection (2) of this section, a carrier may not:

(a) Require an applicant to provide health-related information as a precondition for the issuance of an individual health benefit plan policy; or

(b) Deny coverage under an individual health benefit plan policy based on health-related information provided by the applicant.

(2) A carrier may require an applicant for an individual grandfathered health plan to complete the standard health statement prescribed by the Department of Consumer and Business Services prior to enrollment for the purpose of:

(a) Determining eligibility for coverage; or

(b) Imposing a preexisting condition provision.

(3) A carrier may require an enrollee in a health benefit plan to complete the standard health statement prescribed by the department for the purpose of:

(a) Managing the enrollee's health care; or

(b) Administering:

(A) A program of health promotion or disease prevention, as described in 42 U.S.C. 300gg-4;

(B) A program to promote healthy behaviors under ORS 743.824; or

(C) A wellness program defined by the department by rule. [Formerly 743.751]

**743B.104 Coverage in group health benefit plans; consideration of prospective enrollee health status restricted; effect of discontinuing offer of plans; exceptions; coverage by multiple employer welfare arrangements.** (1) Except in the case of a late enrollee and as otherwise provided in this section, a carrier offering a group health benefit plan to a group of two or more prospective certificate holders shall not decline to offer coverage to any eligible prospective enrollee and shall not impose different terms or conditions on the coverage, premiums or contributions of any enrollee in the group that are based on the actual or expected health status of the enrollee.

(2) A carrier that elects to discontinue offering all of its group health benefit plans under ORS 743B.105 (5)(e), elects to discontinue renewing all such plans or elects to discontinue offering and renewing all such plans is prohibited from offering health benefit plans in the group market in this state for a period of five years from one of the following dates:

(a) The date of notice to the Director of the Department of Consumer and Business Services pursuant to ORS 743B.105 (5)(e); or

(b) If notice is not provided under paragraph (a) of this subsection, from the date on which the director provides notice to the carrier that the director has determined that the carrier has effectively discontinued offering group health benefit plans in this state.

(3) Subsection (1) of this section applies only to group health benefit plans that are not small employer health benefit plans.

(4) Nothing in this section shall prohibit an employer from providing different group health benefit plans to various categories of employees as defined by the employer nor prohibit an employer from providing health benefit plans through different carriers so long as the employer's categories of employees are established in a manner that does not relate to the actual or expected health status of the employees or their dependents.

(5) A multiple employer welfare arrangement, professional or trade association, or other similar arrangement established or maintained to provide benefits to a particular trade, business, profession or industry or their subsidiaries, shall not issue coverage to a group or individual that is not in the same trade, business, profession or industry or their subsidiaries as that covered by the arrangement. The arrangement shall accept all groups and individuals in the same trade, business, profession or industry or their subsidiaries that apply for coverage under the arrangement and that meet the requirements for membership in the arrangement. For purposes of this subsection, the requirements for membership in an arrangement shall not include any requirements that relate to the actual or expected health status of the prospective enrollee. [Formerly 743.752]

**743B.105 Requirements for group health benefit plans other than small employer plans.** The following requirements apply to all group health benefit plans other than small employer health benefit plans covering two or more certificate holders:

(1) A carrier offering a group health benefit plan may not decline to offer coverage to any eligible prospective enrollee and may not impose different terms or conditions on the coverage, premiums or contributions of any enrollee in the group that are based on the actual or expected health status of the enrollee.

(2) A group health benefit plan may not apply a preexisting condition exclusion to any enrollee but may impose:

(a) An affiliation period that does not exceed two months for an enrollee or three months for a late enrollee; or

(b) A group eligibility waiting period for late enrollees that does not exceed 90 days.

(3) Each group health benefit plan shall contain a special enrollment period during which eligible employees and dependents may enroll for coverage, as provided by federal law and rules adopted by the Department of Consumer and Business Services.

(4)(a) A carrier shall issue to a group any of the carrier's group health benefit plans offered by the carrier for which the group is eligible, if the group applies for the plan, agrees to make the required premium payments and agrees to satisfy the other requirements of the plan.

(b) The department may waive the requirements of this subsection if the department finds that issuing a plan to a group or groups would endanger the carrier's ability to fulfill its contractual obligations or result in financial impairment of the carrier.

(5) Each group health benefit plan shall be renewable with respect to all eligible enrollees at the option of the policyholder unless:

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

(b) The policyholder or, with respect to coverage of individual enrollees, an enrollee or a representative of an enrollee engages in fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan.

(c) The number of enrollees covered under the plan is less than the number or percentage of enrollees required by participation requirements under the plan.

(d) The policyholder fails to comply with the contribution requirements under the plan.

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

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

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

(C) May not cancel coverage under the plans for 90 days after the date of the notice required under subparagraph (A) of this paragraph if coverage is discontinued in a specified service area because of an inability to reach an agreement with the health care providers or organization of health care providers to provide services under the plans within the service area.

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

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

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

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

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

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

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

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

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

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

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

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

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

(k) In the case of a group health benefit plan that delivers covered services through a specified network of health care providers, there is no longer any enrollee who lives, resides or works in the service area of the provider network.

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

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

(7) Notwithstanding any provision of subsection (5) of this section to the contrary, a carrier may not rescind the coverage of an enrollee under a group health benefit plan unless:

(a) The enrollee:

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

(B) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan;

(b) The carrier provides at least 30 days' advance written notice, in the form and manner prescribed by the department, to the enrollee; and

(c) The carrier provides notice of the rescission to the department in the form, manner and time frame prescribed by the department by rule.

(8) Notwithstanding any provision of subsection (5) of this section to the contrary, a carrier may not rescind a group health benefit plan unless:

(a) The plan sponsor or a representative of the plan sponsor:

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

(B) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan;

(b) The carrier provides at least 30 days' advance written notice, in the form and manner prescribed by the department, to each plan enrollee who would be affected by the rescission of coverage; and

(c) The carrier provides notice of the rescission to the department in the form, manner and time frame prescribed by the department by rule.

(9) A group health benefit plan may not impose annual or lifetime limits on the dollar amount of essential health benefits. [Formerly 743.754]

**743B.110 Implementation of federal laws; rules.** The Department of Consumer and Business Services may adopt rules incorporating, implementing and administering the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), the Patient Protection and Affordable Care Act (P.L. 111-148) as amended by the Health Care and Education Reconciliation Act (P.L. 111-152) and federal regulations that are issued in conjunction with the Acts. [Formerly 743.758]

**743B.120 Preventive health services; coverage; cost sharing.** Notwithstanding any other provision of law, a health benefit plan that is not a grandfathered health plan:

(1) Must provide coverage of preventive health services as prescribed by the United States Department of Health and Human Services pursuant to 42 U.S.C. 300gg-13; and

(2) May not impose cost-sharing requirements on an enrollee for preventive health services, except as allowed by federal law. [Formerly 743.764]

**743B.125 Individual health benefit plans; waiting or exclusion periods; preexisting condition exclusions; essential health benefits.** (1) With respect to coverage under an individual health benefit plan, a carrier may not impose an individual coverage waiting period.

(2) With respect to individual coverage under a grandfathered health plan, a carrier:

(a) May impose an exclusion period for specified covered services applicable to all individuals enrolling for the first time in the individual health benefit plan.

(b) May not impose a preexisting condition exclusion unless the exclusion complies with the following requirements:

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

(B) The exclusion expires no later than six months after the individual's effective date of coverage.

(3) An individual health benefit plan other than a grandfathered health plan must cover, at a minimum, all essential health benefits.

(4) A carrier shall renew an individual health benefit plan, including a health benefit plan issued through a bona fide association, unless:

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

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

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

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

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

(C) May not cancel coverage under the plans for 90 days after the date of the notice required under subparagraph (A) of this paragraph if coverage is discontinued in a specified service area because of an inability to reach an agreement with the health care providers or organization of health care providers to provide services under the plans within the service area.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) A carrier may modify an individual health benefit plan at the time of coverage renewal. The modification is not a discontinuation of the plan under subsection (4)(c), (e) and (f) of this section.

(6) Notwithstanding any other provision of this section, and subject to the provisions of ORS 743B.310 (2) and (4), a carrier may rescind an individual health benefit plan if the policyholder or a representative of the policyholder:

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

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

(7) A carrier that continues to offer coverage in the individual market in this state is not required to offer coverage in all of the carrier's individual health benefit plans. However, if a carrier elects to continue a plan that is closed to new individual policyholders instead of offering alternative coverage in its other individual health benefit plans, the coverage for all existing policyholders in the closed plan is renewable in accordance with subsection (4) of this section.

(8) An individual health benefit plan may not impose annual or lifetime limits on the dollar amount of essential health benefits.

(9) A grandfathered health plan may not impose lifetime limits on the dollar amount of essential health benefits.

(10) This section does not require a carrier to actively market, offer, issue or accept applications for:

(a) A bona fide association health benefit plan from individuals who are not members of the bona fide association; or

(b) A grandfathered health plan from individuals who are not eligible for coverage under the plan. [Formerly 743.766]

**743B.126 Carrier marketing of individual health benefit plans; rules; duties of carrier regarding applications; effect of discontinuing offer of plans.** (1) Each carrier shall actively market all individual health benefit plans sold by the carrier that are not grandfathered health plans.

(2) Except as provided in subsection (3) of this section, no carrier or insurance producer shall, directly or indirectly, discourage an individual from filing an application for coverage because of the health status, claims experience, occupation or geographic location of the individual.

(3) Subsection (2) of this section does not apply with respect to information provided by a carrier to an individual regarding the established geographic service area or a restricted network provision of a carrier.

(4) Rejection by a carrier of an application for coverage shall be in writing and shall state the reason or reasons for the rejection.

(5) The Director of the Department of Consumer and Business Services may establish by rule additional standards to provide for the fair marketing and broad availability of individual health benefit plans.

(6) A carrier that elects to discontinue offering all of its individual health benefit plans under ORS 743B.125 (4)(c) or to discontinue both offering and renewing all such plans is prohibited from offering and renewing health benefit plans in the individual market in this state for a period of five years from the date of notice to the director pursuant to ORS 743B.125 (4)(c) or, if such notice is not provided, from the date on which the director provides notice to the carrier that the director has determined that the carrier has effectively discontinued offering individual health benefit plans in this state. This subsection does not apply with respect to a health benefit plan discontinued in a specified service area by a carrier that covers services provided only by a particular organization of health care providers or only by health care providers who are under contract with the carrier. [Formerly 743.769]

**743B.127 Rules for ORS 743.022, 743B.125 and 743B.126.** The Director of the Department of Consumer and Business Services shall adopt all rules necessary for the implementation and administration of ORS 743.022, 743B.125 and 743B.126. [Formerly 743.773]

**743B.128 Exceptions to requirement to actively market all plans.** Notwithstanding ORS 743B.012, 743B.013 and 743B.105, a carrier is not required to actively market:

(1) A health benefit plan sold only to a bona fide association, to groups that are not members of the bona fide association;

(2) A grandfathered health plan, to a group or individual who is not eligible for coverage under the plan;

(3) A group health benefit plan, to a group that is not eligible for coverage under the plan;

(4) A qualified health plan sold only through the health insurance exchange, to an individual or group outside of the exchange; or

(5) A policy of group health insurance that may be delivered or issued for delivery in this state without the approval of the Director of the Department of Consumer and Business Services under ORS 742.003 (1). [2015 c.515 §3]

**Note:** 743B.128 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743B or any series therein. See Preface to Oregon Revised Statutes for further explanation.

**743B.130 Requirement to offer bronze and silver plans; rules.** (1) In each individual or small group market, in which a carrier offers a health benefit plan through or outside of the health insurance exchange described in ORS 741.310, the carrier must offer to residents of this state a bronze and a silver plan certified by the Department of Consumer and Business Services as qualified health plans and meeting the requirements of subsection (2) of this section.

(2) The department shall prescribe by rule, in accordance with federal requirements, the form, level of coverage and benefit design for the bronze and silver plans that must be offered under subsection (1) of this section.

(3) As used in this section, "health benefit plan" has the meaning given that term in ORS 743B.005. [Formerly 743.822]

**Note:** 743B.130 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743B or any series therein. See Preface to Oregon Revised Statutes for further explanation.

**743B.195 Enforcement of Newborns' and Mothers' Health Protection Act of 1996.** The Department of Consumer and Business Services shall enforce insurer compliance with the federal Newborns' and Mothers' Health Protection Act of 1996. [Formerly 743.823]

**743B.197 Health Care Consumer Protection Advisory Committee.** The Director of the Department of Consumer and Business Services shall appoint a Health Care Consumer Protection Advisory Committee with fair representation of health care consumers, providers and insurers. The committee shall advise the director regarding the implementation of ORS 743.008, 743A.012, 743B.001, 743B.195, 743B.197, 743B.200, 743B.202, 743B.204, 743B.206, 743B.220, 743B.250, 743B.400, 743B.403, 743B.405, 743B.420, 743B.422, 743B.423, 743B.424 and 743B.550 and other issues related to health care consumer protection. [Formerly 743.827]

### (Temporary provisions relating to transitional health plans)

**Note:** Sections 2 and 32, chapter 515, Oregon Laws 2015, provide:

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

(a) "Carrier" has the meaning given that term in ORS 743.730 [renumbered 743B.005].

(b) "Grandfathered health plan" has the meaning given that term in ORS 743.730.

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

(d) "Transitional grandfathered health benefit plan" means a grandfathered health plan that is issued or renewed by an employer with 51 to 100 employees.

(e) "Transitional health benefit plan" means a health benefit plan, other than a grandfathered health plan, that is:

(A) Before January 1, 2016, issued to or renewed by an employer with 51 to 100 employees on the date the plan is issued or renewed;

(B) In effect on December 31, 2015; and

(C) According to published federal guidance, not subject to enforcement by the United States Department of Health and Human Services, the United States Department of Labor or the United States Department of the Treasury, for compliance with the requirements of:

(i) 42 U.S.C. 300gg;

(ii) 42 U.S.C. 300gg-1;

(iii) 42 U.S.C. 300gg-2;

(iv) 42 U.S.C. 300gg-5;

(v) 42 U.S.C. 300gg-6; and

(vi) 42 U.S.C. 300gg-8.

(2) A transitional health benefit plan and a transitional grandfathered health benefit plan are not subject to the requirements:

(a) In ORS 742.005 (6) unless otherwise required by rule by the Department of Consumer and Business Services;

(b) In ORS 743.736 [renumbered 743B.012];

(c) In ORS 743.737 (1)(a), (8), (10) and (11) [renumbered 743B.013 (1)(a), (8), (10) and (11)]; and

(d) Imposing limitations on participation and contribution rates contained in ORS 743.737.

(3) On and after January 1, 2016, each transitional health benefit plan shall be renewable with respect to all eligible enrollees at the option of the policyholder, employer or contract holder unless the carrier discontinues both offering and renewing the health benefit plan in this state or in a specified service area within this state, other than a plan discontinued in a specified service area within this state:

(a) Because of the inability to reach an agreement with the health care providers or organization of health care providers to provide services under the plan within the service area;

(b) That gives notice of the decision to discontinue the plan to the Department of Consumer and Business Services and to all policyholders covered by the plan;

(c) That does not cancel coverage under the plan for 90 days after the date of the notice required under paragraph (b) of this subsection; and

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

(4) ORS 743.752 (2) [renumbered 743B.104 (2)] does not apply when a carrier discontinues a group health benefit plan due to the change in the definition of "small employer" from an employer with a maximum of 50 employees to an employer with a maximum of 100 employees.

(5) The Department of Consumer and Business Services may modify the requirements of this section or extend or delay the operative date of this section to the extent necessary to comply with published federal guidance described in subsection (1)(e)(C) of this section.

(6) No later than September 1, 2018, the department shall report to the appropriate interim committees of the Legislative Assembly on whether the repeal of this section by section 32 of this 2015 Act should be extended to a later date. [2015 c.515 §2]

**Sec. 32.** Section 2 of this 2015 Act is repealed on January 2, 2020. [2015 c.515 §32]

## MANAGED HEALTH INSURANCE

**743B.200 Requirements for insurers offering managed health insurance; quality assessment; rules.** All insurers offering managed health insurance in this state shall:

(1) Have a quality assessment program that enables the insurer to evaluate, maintain and improve the quality of health services provided to enrollees. The program shall include data gathering that allows the plan to measure progress on specific quality improvement goals chosen by the insurer.

(2) File an annual summary with the Department of Consumer and Business Services that describes quality assessment activities, including any activities related to credentialing of providers, and reports any progress on the insurer's quality improvement goals.

(3) File annually with the department the following information:

(a) Results of all publicly available federal Centers for Medicare and Medicaid Services reports and accreditation surveys by national accreditation organizations.

(b) The insurer's health promotion and disease prevention activities, if any, including a summary of screening and preventive health care activities covered by the insurer. In addition to the summary required in this paragraph, the consortium established pursu-

ant to ORS 743B.206 shall develop recommendations for, and the department shall adopt rules requiring, reporting of an insurer's health promotion and disease prevention activities related to:

(A) Two specific preventive measures;

(B) One specific chronic condition; and

(C) One specific acute condition. [Formerly 743.814]

**743B.202 Requirements for insurers offering managed health or preferred provider organization insurance; rules; opportunity to participate.** An insurer offering managed health insurance or preferred provider organization insurance in this state shall:

(1) File an annual summary with the Department of Consumer and Business Services that reports on the scope and adequacy of the insurer's network and the insurer's ongoing monitoring to ensure that all covered services are reasonably accessible to enrollees. The Director of the Department of Consumer and Business Services shall adopt rules establishing uniform indicators that insurers offering managed health insurance or preferred provider organization insurance must use for reporting under this subsection, including but not limited to reporting on the scope and adequacy of networks. For the purpose of developing the rules, the director shall consult with an advisory committee appointed by the director. The advisory committee must include representatives of persons likely to be affected by the rules, including consumers, purchasers of health insurance and insurers that offer managed health insurance or preferred provider organization insurance.

(2) Establish a means to provide to the insurer's managed care plan or preferred provider organization insurance enrollees, purchasers and providers a meaningful opportunity to participate in the development and implementation of insurer policy and operation through:

(a) The establishment of advisory panels;

(b) Consultation with advisory panels on major policy decisions; or

(c) Other means including but not limited to:

(A) Governing board meetings or special meetings at which enrollees, purchasers and providers are invited to express opinions; and

(B) Enrollee councils that are given a reasonable opportunity to meet with the governing board or its designee. [Formerly 743.817]

**743B.204 Required managed health insurance contract provision; enrollee liability.** All insurers offering managed health insurance in this state shall include in contracts with providers a provision requiring that in the event the insurer fails to pay for health care services covered by the health benefit plan, the provider shall not bill or otherwise attempt to collect from enrollees for amounts owed by insurers, and enrollees shall not be liable to the provider for any sums owed by the insurer. Nothing in this section shall be construed to in any manner limit the applicability of ORS 750.095 (2). [Formerly 743.821]

**743B.206 Consortium established; managed health care performance.** (1) The Oregon Health Authority shall establish a consortium of interested parties that shall:

(a) Develop, on a voluntary basis, standardized, quantitative performance measurements of managed health insurance organizations for use by health care consumers, purchasers and providers to continuously assess the quality of clinical and service-related aspects of health care arranged for or provided by managed health insurance organizations;

(b) Encourage managed health insurance organizations to collect, on a voluntary basis, the performance measurements specified in paragraph (a) of this subsection and share that information with the consortium;

(c) Develop, test, refine and produce one or more managed health care performance scorecards to provide consumers and purchasers with accurate, reliable and timely comparisons of managed health insurance organizations with respect to:

(A) Organizational characteristics;

(B) Clinical quality measurements;

(C) Service-related quality measurements; and

(D) Member and patient satisfaction; and

(d) Carry out the activities specified in this subsection with the objective of:

(A) Utilizing, to the greatest extent feasible and desirable, nationally developed quality assessment tools; and

(B) Minimizing duplicative quality assessment activities and associated administrative costs.

(2) The consortium established pursuant to subsection (1) of this section shall be comprised of representatives of:

(a) Health care consumers;

(b) Private-sector and public-sector health care purchasers;

(c) Managed health insurance organizations;

(d) Health care providers, including but not limited to physicians, nurses and hospitals;

(e) State agencies, including but not limited to the Department of Consumer and Business Services;

(f) Oregon institutions of higher education with relevant professional expertise; and

(g) Other groups or organizations as determined to be appropriate by the authority to ensure broad representation of interests and expertise.

(3) The authority shall:

(a) Provide staffing for the consortium; and

(b) Seek public and private funds to assist in the work of the consortium. [Formerly 743.831]

**743B.220 Requirements for insurers that require designation of participating primary care physician; exceptions.** (1) All insurers offering a health benefit plan in this state that requires an enrollee to designate a participating primary care physician shall:

(a) Permit the enrollee to change participating primary care physicians at will, except that the enrollee may be restricted to making changes no more frequently than two times in any 12-month period and may be limited to designating only those participating primary care physicians accepting new patients.

(b) Have available for employer purchasers of group health plans a point-of-service benefit plan providing for payment for the services of a provider on a fee-for-service or discounted fee-for-service basis with reasonable access to a broad array of licensed providers in the insurer's geographic service area. Any higher premium for the point-of-service benefit plan may not exceed true actuarial cost, including administrative costs, to the insurer.

(2) A health maintenance organization that is exempt from federal income tax under Internal Revenue Code section 501(c)(3) or (4) shall not be required to offer a point-of-service benefit plan as required by subsection (1)(b) of this section if offering such a plan could result in loss of federal tax-exempt status. Until such time as the federal government establishes guidelines for health maintenance organizations exempt from federal income tax that offer point-of-service benefit plans, such a health maintenance organization shall not be required to offer a point-of-service benefit plan if:

(a) Enrollment in Internal Revenue Code section 501(m) coverages exceeds five percent of its business; or

(b) Revenue from Internal Revenue Code section 501(m) coverages exceeds five percent of its revenue.

(3) A health maintenance organization that is federally qualified under 42 U.S.C. 300e et seq. shall not be required to offer a point-of-service benefit plan in a manner or to an extent that is inconsistent with federal law and regulation. [Formerly 743.808]

**743B.222 Designation of women's health care provider as primary care provider; direct access to women's health care provider.** (1) As used in this section, "women's health care provider" means an obstetrician or gynecologist, physician assistant specializing in women's health, advanced registered nurse practitioner specialist in women's health or certified nurse midwife, practicing within the applicable lawful scope of practice.

(2) Every health insurance policy that covers hospital, medical or surgical expenses and requires an enrollee to designate a participating primary care provider shall permit a female enrollee to designate a women's health care provider as the enrollee's primary care provider if:

(a) The women's health care provider meets the standards established by the insurer in collaboration with interested parties, including but not limited to the Oregon section of the American College of Obstetricians and Gynecologists; and

(b) The women's health care provider requests that the insurer make the provider available for designation as a primary care provider.

(3) If a female enrollee has designated a primary care provider who is not a women's health care provider, an insurance policy as described in subsection (2) of this section shall permit the enrollee to have direct access to a women's health care provider, without a referral or prior authorization, for obstetrical or gynecological care by a participating health care professional who specializes in obstetrics or gynecology.

(4) The standards established by the insurer under subsection (2) of this section shall not prohibit an insurer from establishing the maximum number of participating primary care providers and participating women's health care providers necessary to serve a defined population or geographic service area. [Formerly 743.845]

**743B.225 Continuity of care.** (1) As used in this section, "continuity of care" means the feature of a health benefit plan under

which an enrollee who is receiving care from an individual provider is entitled to continue with care with the individual provider for a limited period of time after the medical services contract terminates.

(2) An insurer offering managed health insurance or preferred provider organization insurance in this state shall provide continuity of care to an enrollee under a health benefit plan if:

(a) A medical services contract or other contract for an individual provider's services is terminated;

(b) The provider no longer participates in the provider network; and

(c) The insurer does not cover services when services are provided to enrollees by the individual provider or covers services at a benefit level below the benefit level specified in the plan for out-of-network providers.

(3) In order to obtain continuity of care, an enrollee must request continuity of care from the insurer.

(4) An enrollee of a health benefit plan is entitled to continuity of care when the following conditions are met:

(a) The enrollee is undergoing an active course of treatment that is medically necessary and, by agreement of the individual provider and the enrollee, it is desirable to maintain continuity of care; and

(b) The contractual relationship between the individual provider and the insurer described in subsection (2) of this section with respect to the plan covering the enrollee has ended, except as provided in subsection (5) of this section.

(5) A health benefit plan is not required to provide continuity of care when the contractual relationship between the individual provider and the insurer described in subsection (2) of this section ends under one of the following circumstances:

(a) The contractual relationship between the individual provider and the insurer has ended because the individual provider:

(A) Has retired;

(B) Has died;

(C) No longer holds an active license;

(D) Has relocated out of the service area;

(E) Has gone on sabbatical; or

(F) Is prevented from continuing to care for patients because of other circumstances; or

(b) The contractual relationship has terminated in accordance with provisions of the medical services contract relating to quality of care and all contractual appeal rights of the individual provider have been exhausted.

(6) A health benefit plan is not required to provide continuity of care if the enrollee leaves a health benefit plan or if the policyholder discontinues the plan in which the enrollee is enrolled.

(7) Except as provided for pregnancy in subsection (8) of this section, an enrollee who is entitled to continuity of care shall receive the care until the earlier of the following dates:

(a) The day following the date on which the active course of treatment entitling the enrollee to continuity of care is completed; or

(b) The 120th day after the date of notification by the insurer to the enrollee of the termination of the contractual relationship with the individual provider, as required by subsection (9) of this section.

(8) An enrollee who is undergoing care for a pregnancy and who becomes entitled to continuity of care after commencement of the second trimester of the pregnancy shall receive the care until the later of the following dates:

(a) The 45th day after the birth; or

(b) As long as the enrollee continues under an active course of treatment, but not later than the 120th day after the date of notification by the insurer to the enrollee of the termination of the contractual relationship with the individual provider as required by subsection (9) of this section.

(9) An insurer shall give written notice of the termination of the contractual relationship between the insurer and the individual provider and of the right to obtain continuity of care to those enrollees that the insurer knows or reasonably should know are under the care of the individual provider. The notice may be given prior to the date on which the termination of the contractual relationship with the individual provider takes effect only if the insurer gives notice in a good faith belief that the termination will take effect as stated in the notice. In any event, the notice shall be given to those enrollees not later than the 10th day after the date on which the termination of the contractual relationship with the individual provider takes effect. If the insurer first learns the identity of an affected enrollee after the date of termination of the contractual relationship with the individual provider or after the date on which the insurer gave notice to the other affected enrollees, then the insurer shall give a notice of termination to the affected enrollee not later than the 10th day after learning that enrollee's identity.

(10) For the purpose of notifying an enrollee under subsection (7)(b) or (8)(b) of this section:

(a) The date of notification by the insurer is the earlier of the date on which the enrollee receives the notice or the date on which the insurer receives or approves the request for continuity of care.

(b) If an individual provider belongs to a provider group, the provider group may deliver the notice if the insurer agrees that the provider group may do so and if the notice clearly provides the information that the plan is required to provide to the enrollee under subsection (9) of this section.

(11) A health benefit plan may condition continuity of care upon the requirement that the individual provider adhere to the medical services contract between the provider and the insurer and accept the contractual reimbursement rate applicable at the time of contract termination or, if the contractual reimbursement rate was not based on a fee for service, a rate equivalent to the contractual rate. [Formerly 743.854]

**743B.227 Referrals to specialists.** (1) If an insurer offers a health benefit plan that requires, as a condition of coverage for specialty care services, a referral by a physician who is authorized under the plan or under the medical services contract between the physician and the insurer to refer an enrollee to specialty care services, the insurer must include the requirements of this section in the plan. The requirements apply only to benefits for which the member is contractually eligible under the plan. The requirements are as follows:

(a) The plan must establish and implement a procedure for standing referrals, so that an enrollee is not required to obtain approval from the authorized physician for each appointment with a specialist after the initial appointment.

(b) The plan must allow a standing referral for an enrollee if the authorized physician determines that the enrollee needs continuing care from a specialist.

(c) The plan must allow an enrollee to request and obtain a second medical opinion or consultation from a second physician who is a network provider and who is authorized to make decisions regarding the need for a referral to a specialist. If the plan does not have a network provider available to give a second medical opinion or consultation, the plan must allow the enrollee to obtain the opinion or consultation from a similarly qualified physician who is not a network provider. The plan may not impose a charge for the second medical opinion or consultation that is greater than the cost that the enrollee would otherwise pay for an initial medical opinion or consultation from the second physician.

(2) A specialist to whom an enrollee is referred must make regular reports to the authorized physician under subsection (1) of this section in accordance with best practices for coordinated care as established by the insurer. [Formerly 743.856]

## GRIEVANCES AND APPEALS

**743B.250 Required notices to applicants and enrollees; grievances, internal appeals and external reviews.** 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.

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

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

(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 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 (6)(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. [Formerly 743.804]

**Note:** The amendments to 743B.250 (formerly 743.804) by section 5, chapter 59, Oregon Laws 2015, become operative January 1, 2017 and apply to health benefit plans in effect on or after January 1, 2017. See section 11, chapter 59, Oregon Laws 2015. The text that is operative on and after January 1, 2017, is set forth for the user's convenience.

**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.

(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.

(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 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.

**743B.252 External review; rules.** (1) An insurer offering health benefit plans in this state shall have an external review program that meets the requirements of this section and ORS 743B.255 and rules adopted by the Director of the Department of Consumer and Business Services to carry out the provisions of this section and ORS 743B.255. Each insurer shall provide the external review through an independent review organization that is under contract with the director to provide external review. Each health benefit plan must allow an enrollee, by applying to the insurer or the director, to obtain review by an independent review organization of a dispute relating to an adverse benefit determination by the insurer on one or more of the following:

(a) Whether a course or plan of treatment is medically necessary.

(b) Whether a course or plan of treatment is experimental or investigational.

(c) Whether a course or plan of treatment that an enrollee is undergoing is an active course of treatment for purposes of continuity of care under ORS 743B.225.

(d) Whether a course or plan of treatment is delivered in an appropriate health care setting and with the appropriate level of care.

(2) An insurer shall incur all costs of its external review program. The insurer may not establish or charge a fee payable by enrollees for conducting external review.

(3) When an enrollee applies for external review, the director shall appoint an independent review organization. When an independent review organization is appointed, the insurer shall forward all medical records and other relevant materials to the independent review organization no later than five business days after the appointment. The insurer shall produce additional information as requested by the independent review organization to the extent that the information is reasonably available to the insurer. An independent review organization may reverse the adverse benefit determination if the insurer fails to furnish records, information and materials to the independent review organization in a timely manner.

(4) An enrollee may submit additional information to the independent review organization no later than five business days after the enrollee's receipt of notification of the appointment of the independent review organization and the organization must consider the information in its review.

(5) The insurer and the director shall expedite the external review:

(a) If the adverse benefit determination concerns an admission, the availability of care, a continued stay or a health care service for a medical condition for which the enrollee received emergency services, as defined in ORS 743A.012, and has not been discharged from a health care facility; or

(b) If a provider with an established clinical relationship to the enrollee certifies in writing and provides supporting documentation that the ordinary time period for external review would seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. [Formerly 743.857]

**743B.253 Director to contract with independent review organizations to provide external review; rules.** (1) The Director of the Department of Consumer and Business Services shall contract with independent review organizations as provided in this section for the purpose of providing external review under ORS 743B.252. The director may have contracts with no more than five independent review organizations at any one time. Contracts shall be let with independent review organizations on a biennial basis. A contract may be renewed if both parties agree.

(2) The director shall seek public comment when the director proposes to enter into a contract with an independent review organization or proposes to renew or not renew a contract.

(3) When evaluating proposals to contract with independent review organizations, the director shall consider factors that include but are not limited to relative expertise, professionalism, quality of compliance with the rules established under subsection (4) of this section, cost and record of past performance.

(4) The director shall adopt rules governing independent review organizations, their composition and their conduct. The rules shall include but need not be limited to:

(a) Professional qualifications of health care providers, physicians or contract specialists making external review determinations;

(b) Criteria requiring independent review organizations to demonstrate protections against bias and conflicts of interest;

(c) Procedures for conducting external reviews;

(d) Procedures for complaint investigations;

(e) Procedures for ensuring the confidentiality of medical records transmitted to the independent review organizations for use in external reviews;

(f) Fairness of procedures used by independent review organizations;

(g) Fees for external reviews;

(h) Timelines for decision making and notice to the parties; and

(i) Quality assurance mechanisms to ensure timeliness and quality of review.

(5) The director shall develop procedures for assigning cases filed by enrollees to independent review organizations under contract with the director. The cases shall be assigned on a random basis. The procedures shall allow an insurer only one opportunity to reject the assignment of an independent review organization to a particular case. [Formerly 743.858]

**743B.254 Notice to enrollee of right to sue if insurer does not follow decision of independent review organization.** An insurer of a health benefit plan shall include in the plan the following statements, in boldfaced type or otherwise emphasized:

(1) A statement of the right of enrollees to apply for external review by an independent review organization; and

(2) A statement that if the insurer does not follow a decision of an independent review organization, the enrollee has the right to sue the insurer. [Formerly 743.859]

**743B.255 Enrollee application for external review; when enrollee deemed to have exhausted internal appeal.** (1) An enrollee shall apply in writing for external review of an adverse benefit determination by the insurer of a health benefit plan not later than the 180th day after receipt of the insurer's final written decision following its grievance and internal appeal process under ORS 743B.250. An enrollee is eligible for external review only if the enrollee has satisfied the following requirements:

(a) The enrollee must have signed a waiver granting the independent review organization access to the medical records of the enrollee.

(b) The enrollee must have exhausted the plan's internal appeal procedures established pursuant to ORS 743B.250 or be deemed to have exhausted the plan's internal appeal procedures. The insurer may waive the requirement of compliance with the internal appeal procedures and have a dispute referred directly to external review upon the enrollee's consent. An enrollee is deemed to have exhausted the internal appeal procedures if the insurer fails to strictly comply with ORS 743B.250 and federal requirements for internal appeals.

(2) An enrollee who applies for external review of an adverse benefit determination shall provide complete and accurate information to the independent review organization as provided in ORS 743B.252. [Formerly 743.861]

**743B.256 Duties of independent review organizations; expedited reviews.** (1) An independent review organization shall perform the following duties when appointed under ORS 743B.252 to review a dispute under a health benefit plan between an insurer and an enrollee:

(a) Decide whether the dispute pertains to an adverse benefit determination and notify the enrollee and insurer in writing of the decision. If the decision is against the enrollee, the independent review organization shall notify the enrollee of the right to file a complaint with or seek other assistance from the Department of Consumer and Business Services and the availability of other assistance as specified by the department.

(b) Appoint a reviewer or reviewers as determined appropriate by the independent review organization.

(c) Notify the enrollee of information that the enrollee is required to provide and any additional information the enrollee may provide, and when the information must be submitted as provided in ORS 743B.252.

(d) Notify the insurer of additional information the independent review organization requires and when the information must be submitted as provided in ORS 743B.252.

(e) Decide the dispute relating to the adverse benefit determination of the insurer and issue the decision in writing.

(2) A decision by an independent review organization shall be based on expert medical judgment after consideration of the enrollee's medical record, the recommendations of each of the enrollee's providers, relevant medical, scientific and cost-effectiveness evidence and standards of medical practice in the United States. An independent review organization must make its decision in accordance with the coverage described in the health benefit plan, except that the independent review organization may override the insurer's standards for medically necessary or experimental or investigational treatment if the independent review organization determines that the standards of the insurer are unreasonable or are inconsistent with sound medical practice.

(3) When review is expedited, the independent review organization shall issue a decision not later than the third day after the date on which the enrollee applies to the insurer for an expedited review or the Director of the Department of Consumer and Business Services orders an expedited review.

(4) When a review is not expedited, the independent review organization shall issue a decision not later than the 30th day after the enrollee applies to the insurer for a review or the director orders a review.

(5) An independent review organization shall file synopses of its decisions with the director according to the format and other requirements established by the director. The synopses shall exclude information that is confidential, that is otherwise exempt from disclosure under ORS 192.501 and 192.502 or that may otherwise allow identification of an enrollee. The director shall make the synopses public. [Formerly 743.862]

**743B.257 Civil penalty for failure to comply by insurer that agreed to be bound by decision.** (1) An insurer shall comply in a timely manner with a decision of an independent review organization under ORS 743B.256 that reverses, in whole or in part, an adverse benefit determination. If an insurer fails to comply with the decision, the Director of the Department of Consumer and Business Services may impose on the insurer a civil penalty of not more than $1 million.

(2) A decision of an independent review organization is admissible in any legal proceeding involving the insurer or the enrollee and involving the disputed issues subject to external review.

(3) The sanctions under subsection (1) of this section and the remedies under subsection (2) of this section are in addition to and not in lieu of other sanctions, rights and remedies provided by law or contract. [Formerly 743.863]

**743B.258 Private right of action.** (1) An enrollee who is the subject of a decision of an independent review organization has a private right of action against the insurer for damages arising from an adverse benefit determination by the insurer that is subject to external review if the insurer fails to comply with the decision.

(2) The Legislative Assembly intends that there is no private right of action under subsection (1) of this section if a court finds subsection (1) of this section to be unconstitutional or otherwise void. [Formerly 743.864]

## OUT-OF-POCKET COSTS

**743B.280 Definitions for ORS 743B.280 to 743B.285.** As used in ORS 743B.280 to 743B.285:

(1) "In-network" means performed by a provider or provider group that has directly contracted with the insurer.

(2) "Out-of-network" means performed by a provider or provider group that has not contracted or has indirectly contracted with the insurer. [Formerly 743.871]

**Note:** 743B.280 to 743B.285 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 743B or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

**743B.281 Estimate of costs for in-network procedure or service.** (1) An insurer offering a health benefit plan as defined in ORS 743B.005 must establish a procedure for providing to an enrollee in the plan a reasonable estimate of an enrollee's costs for an in-network procedure or service covered by the enrollee's health benefit plan, in advance of the procedure or service, when an enrollee or an enrollee's authorized representative provides the following information to the insurer:

(a) The type of procedure or service;

(b) The name of the provider;

(c) The enrollee's member number or policy number; and

(d) If requested by the insurer, the site where the procedure or service will be performed.

(2) The estimate of costs described in subsection (1) of this section must include an itemization of:

(a) The enrollee's deductible;

(b) The amount of the deductible that has been met by processed claims;

(c) Coinsurance, copayment or other cost share to be paid by the enrollee for the procedure or service; and

(d) Any applicable benefit maximum.

(3) Subsections (1) and (2) of this section apply to the insurer's five most common procedures or services within each of the following categories:

(a) Office visits;

(b) Diagnostic radiology and imaging;

(c) Diagnostic pathology and laboratory procedures;

(d) Normal vaginal delivery;

(e) Immunizations;

(f) Orthopedic-musculoskeletal surgery; and

(g) Digestive system endoscopy.

(4) In addition to the information specified in subsections (1) and (2) of this section, the insurer's estimate must include the following disclosures:

(a) That other services may be provided to the enrollee that are medically necessary and appropriate as part of the common procedures, of which the insurer or enrollee may not be aware at the time of the inquiry and for which the enrollee may have additional financial responsibility;

(b) That the enrollee may be responsible for costs of procedures or services not covered by the plan;

(c) How an enrollee may contact the insurer for an explanation, if the estimate differs from the actual cost or if the enrollee has other questions; and

(d) The toll-free telephone number of the consumer advocacy unit of the Department of Consumer and Business Services and the address for the department's consumer information and complaints website.

(5) An insurer must make the information required by this section available to enrollees and in-network providers through an interactive website and by toll-free telephone.

(6) This section does not prohibit an insurer from providing information in addition to or in more detail than the information required by this section. [Formerly 743.874]

**Note:** See note under 743B.280.

**743B.282 Estimate of costs for out-of-network procedure or service.** (1) An insurer offering a health benefit plan as defined in ORS 743B.005 must establish a procedure for providing to an enrollee in the plan a reasonable estimate of the enrollee's costs for an out-of-network procedure or service covered by the enrollee's health benefit plan, including the difference between the insurer's allowable charge and the billed charge for the procedure or service, in advance of the procedure or service, when an enrollee or an enrollee's authorized representative provides the following information to the insurer:

(a) The type of procedure or service;

(b) The name of the provider;

(c) The enrollee's member number or policy number;

(d) If requested by the insurer, the site where the procedure or service will be performed; and

(e) The provider's billed charge amount.

(2) The estimate of costs described in subsection (1) of this section must include an itemization of:

(a) The enrollee's deductible;

(b) The amount of the deductible that has been met by processed claims;

(c) Coinsurance, copayment or other cost share to be paid by the enrollee for the procedure or service;

(d) Any applicable benefit maximum;

(e) The difference between the insurer's allowable charge and the billed charge for the procedure or service; and

(f) The insurer's average payment or allowable charge for the procedure or service if performed in-network.

(3) Subsections (1) and (2) of this section apply to the insurer's five most common procedures or services within each of the following categories:

(a) Office visits;

(b) Diagnostic radiology and imaging;

(c) Diagnostic pathology and laboratory procedures;

(d) Normal vaginal delivery;

(e) Immunizations;

(f) Orthopedic-musculoskeletal surgery; and

(g) Digestive system endoscopy.

(4) In addition to the information specified in subsections (1) and (2) of this section, the insurer's estimate must include the following disclosures:

(a) That other services may be provided to the enrollee that are medically necessary and appropriate as part of the common procedures, of which the insurer or enrollee may not be aware at the time of the inquiry and for which the enrollee may have additional financial responsibility;

(b) That the enrollee may be responsible for costs of procedures or services not covered by the plan;

(c) How an enrollee may contact the insurer for an explanation, if the estimate differs from the actual cost or if the enrollee has other questions; and

(d) The toll-free telephone number of the consumer advocacy unit of the Department of Consumer and Business Services and the address for the department's consumer information and complaints website.

(5) An insurer must make the information required by this section available to enrollees and out-of-network providers through an interactive website and by toll-free telephone.

(6) This section does not prohibit an insurer from providing information in addition to or in more detail than the information required by this section. [Formerly 743.876]

**Note:** See note under 743B.280.

**743B.283 Submission of methodology used to determine insurer's allowable charges.** An insurer offering a health benefit plan as defined in ORS 743B.005 must submit to the Director of the Department of Consumer and Business Services:

(1) Upon request by the director, the methodology used to determine the insurer's allowable charges for out-of-network procedures and services or, if the insurer uses a third party to determine the charges, the methodology used by the third party to determine allowable charges;

(2) For approval, a written explanation of the method used by the insurer to determine the allowable charge, that is in plain language and that must be provided upon request to enrollees directly, or, in the case of group coverage, to the employer or other policyholder for distribution to enrollees; and

(3) Information prescribed by the director as necessary to assess the effect of the disclosure requirements in ORS 743B.281 and 743B.282 on the individual and group health insurance markets. [Formerly 743.878]

**Note:** See note under 743B.280.

**743B.284 Alternative mechanism for disclosure of costs and charges.** The Director of the Department of Consumer and Business Services may waive the requirements of ORS 743B.281 or 743B.282 to allow an insurer to use an alternative disclosure mechanism, provided that the mechanism enables enrollees to access information substantially similar to or more extensive than the information disclosed in ORS 743B.281 or 743B.282. [Formerly 743.883]

**Note:** See note under 743B.280.

**743B.285 Rules.** The Director of the Department of Consumer and Business Services shall adopt rules necessary to carry out the purposes of ORS 743B.280 to 743B.285. [Formerly 743.893]

**Note:** See note under 743B.280.

## SUBSTITUTION, RESCISSION, TERMINATION AND CONTINUATION

### (Substitution)

**743B.300 Disclosure of differences in replacement health insurance policies; nonduplication for persons 65 and older; rules.** (1) The Director of the Department of Consumer and Business Services shall adopt by rule requirements for disclosure by group and individual health insurers to individual and group health insurance policyholders the difference between coverage under the existing policy and coverage being offered to replace that coverage.

(2) The provisions of this section do not apply to disability income insurance.

(3) The director shall adopt by rule requirements for nonduplication and replacement of major medical, Medicare supplement, long term care and special illness policies for applicants 65 years of age and older. The insurance producer shall offer to compare for any applicants 65 years of age and older the applicant's existing policy or policies and coverage being offered to replace or supplement the applicant's existing coverage. [Formerly 743.013]

### (Rescission)

**743B.310 Rescinding coverage; permissible bases; notice; rules.** (1) As used in this section, "rescind" means to retroactively cancel or discontinue coverage under a health benefit plan or group or individual health insurance policy for reasons other than failure to timely pay required premiums or required contributions toward the cost of coverage.

(2) An insurer may not rescind coverage of an individual under a health benefit plan or group or individual health insurance policy unless:

(a) The individual or a person seeking coverage on behalf of the individual:

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

(B) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan or policy; and

(b) The insurer provides at least 30 days' advance written notice, in the form and manner prescribed by the Department of Consumer and Business Services, to the individual.

(3) An insurer may not rescind coverage of a group under a health benefit plan unless:

(a) The plan sponsor:

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

(B) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan; and

(b) The insurer provides at least 30 days' advance written notice, in the form and manner prescribed by the department, to each plan enrollee or policy holder who would be affected by the rescission of coverage.

(4) An insurer that rescinds a plan or policy must provide notice of the rescission to the department in the form, manner and time frame prescribed by the department by rule.

(5) This section does not apply to long term care insurance that is subject to ORS 743.650 to 743.665. [Formerly 743.894]

**Note:** 743B.310 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743B or any series therein. See Preface to Oregon Revised Statutes for further explanation.

**(Termination)**

**743B.320 Minimum grace period; notice upon termination of policy; effect of failure to notify.** (1) A group health insurance policy shall contain a provision allowing a minimum grace period of 10 days after the premium due date for payment of premium.

(2) An insurer of a group health insurance policy providing coverage for hospital or medical expenses, other than coverage limited to expenses from accidents or specific diseases, that seeks to terminate a policy for nonpayment of premium shall notify the policyholder as described in ORS 743B.323.

(3) An insurer of a group health insurance policy providing coverage for hospital or medical expenses, other than coverage limited to expenses from accidents or specific diseases, shall notify the group policyholder when the policy is terminated and the coverage is not replaced by the group policyholder. The notice required under this subsection:

(a) Must be given on a form prescribed by the Department of Consumer and Business Services;

(b) Must explain the rights of the certificate holders regarding continuation of coverage provided by federal and state law; and

(c) Must be given by mail and must be mailed not later than 10 working days after the date on which the group policy terminates according to the terms of the policy.

(4) A group health insurance policy to which subsection (3) of this section applies shall contain a provision requiring the insurer to notify the group policyholder when the policy is terminated and the coverage is not replaced by the group policyholder. Each certificate issued under the policy shall also contain a statement of the provision required under this subsection.

(5) If an insurer fails to give notice as required by this section, the insurer shall continue the group health insurance policy of the group policyholder in full force from the date notice should have been provided until the date that the notice is received by the policyholder and shall waive the premiums owing for the period for which the coverage is continued under this subsection. The time period within which the certificate holder may exercise any right to continuation shall commence on the date that the policyholder receives the notice.

(6) The insurer shall supply the employer holding the terminated policy with the necessary information for the employer to be able to notify properly the employee of the employee's right to continuation of coverage under state and federal law. [Formerly 743.560]

**743B.321 Applicability of ORS 743B.320.** ORS 743B.320 applies to multiple employer trusts when an employer ceases to participate therein. [Formerly 743.562]

**743B.323 Separate notice to policyholder required before cancellation of individual or group health insurance policy for nonpayment of premium.** Before a health insurer selling an individual policy or group health benefit plan, as defined in ORS 743B.005, may cancel a policy for nonpayment of premium, the insurer must mail a separate notice to the policyholder at least 10 days prior to the end of the grace period informing the policyholder that the premium was not received and that the policy will be terminated as of the premium due date if the premium is not received by the end of the applicable grace period required by ORS 743.417 and 743B.320. The notice shall be in writing and mailed by first class mail to the last-known address of the policyholder. [Formerly 743.565]

**743B.324 Rules for certain notice requirements.** The Director of the Department of Consumer and Business Services shall adopt rules necessary for the implementation and administration of ORS 743B.323 and the amendments to ORS 743.417, 743.420, 743B.013, 743B.105, 743B.125 and 743B.320 by sections 9 to 14, chapter 943, Oregon Laws 2001. [Formerly 743.566]

**Note:** 743B.324 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 743B or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

**743B.330 Notice to policyholder required for cancellation or nonrenewal of health benefit plan; effect of failure to give notice.** (1) As used in this section, "health benefit plan" has the meaning given that term in ORS 743B.005.

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

(3) If the cancellation or nonrenewal results in a refund to the policyholder of all or

part of a premium, the insurer must mail with the refund a written explanation that includes:

(a) The effective date of the cancellation;

(b) The reason for the cancellation; and

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

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

(a) Confirm the accuracy of the reported death.

(b) If the death is confirmed:

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

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

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

(6) This section does not apply:

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

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

(c) To a cancellation due to nonpayment of premium. [Formerly 743.499]

**Note:** 743B.330 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743B or any series therein. See Preface to Oregon Revised Statutes for further explanation.

**(Continuation)**

**743B.340 When group health insurance policies to continue in effect upon payment of premium by insured individual.** (1) Every group health insurance policy delivered or issued for delivery in this state shall contain in substance the following provisions, applicable to the coverage for hospital or medical services or expenses provided under the policy:

(a) A provision that, when the premium for the policy or any part thereof is paid by an employer under the terms of a collective bargaining agreement, if there is a cessation of work by employees insured under the policy due to a strike or lockout, the policy, upon timely payment of the premium, will continue in effect with respect to those employees insured by the policy on the date of the cessation of work who continue to pay their individual contribution and who assume and pay the contribution due from the employer.

(b) A provision that, when an employee insured under the policy pays a contribution pursuant to paragraph (a) of this subsection, if the policyholder is not a trustee of a fund established or maintained in whole or in part by an employer, the employee's individual contribution shall be:

(A) The rate in the policy, on the date cessation of work occurs, applicable to an individual in the class to which the employee belongs as set forth in the policy; or

(B) If the policy does not provide for a rate applicable to individuals, an amount equal to the amount determined by dividing the total monthly premium in effect under the policy at the date of cessation of work by the total number of persons insured under the policy on such date.

(c) A provision that, when an employee insured under the policy pays a contribution pursuant to paragraph (a) of this subsection, if the policyholder is a trustee of a fund established or maintained in whole or in part by an employer, the employee's individual contribution shall be the amount which the employee and employer would have been required to contribute if the cessation of work had not occurred.

(2) Every group health insurance policy delivered or issued for delivery in this state may contain in substance the following provisions applicable to the coverage for hospital or medical services or expenses provided under the policy:

(a) A provision that, when employees insured under the policy pay contributions pursuant to subsection (1)(a) of this section, the continuation of insurance under the policy is contingent upon the collection of individual contributions by the union representing the employees when the policyholder is not a trustee and by the policyholder or the policyholder's agent when the policyholder is a trustee.

(b) A provision that, when employees insured under the policy pay contributions pursuant to subsection (1)(a) of this section, the continuation of insurance under the policy on each employee is contingent upon

timely payment of contributions by the employees and timely payment of the premium by the entity responsible for collecting the individual contributions.

(c) A provision that, when employees insured under the policy pay contributions pursuant to subsection (1)(a) of this section, each individual premium rate under the policy may be increased by not more than 20 percent, or by any higher percentage approved by the Director of the Department of Consumer and Business Services, during the period of cessation of work in order to provide sufficient compensation to the insurer for increased administrative costs and increased mortality and morbidity. If the policy contains the provision allowed under this paragraph, an employee's contribution paid under subsection (1)(a) of this section shall be increased by the same percentage.

(d) A provision that, when the policy is a policy insuring employees and which may continue in effect as provided in subsection (1)(a) of this section, if the premium is unpaid at the date of cessation of work and the premium became due prior to such cessation of work, the continuation of insurance is contingent upon payment of the premium prior to the date the next premium becomes due under the terms of the policy.

(e) Any provision with respect to the continuation of the policy as provided in subsection (1)(a) of this section that the director may approve.

(3) Nothing in this section shall be deemed to limit any right which the insurer may have in accordance with the terms of a policy to increase or decrease the premium rates before, during or after a cessation of work by employees insured under the policy when the insurer had the right to increase the premium rates even if the cessation of work did not occur. If such a premium rate change is made, it shall be effective on such date as the insurer shall determine in accordance with the terms of the policy.

(4) Nothing in this section shall be deemed to require continuation of any coverage in a group health insurance policy insuring employees and which may continue in effect as provided in subsection (1)(a) of this section for longer than:

(a) The time that 75 percent of insured employees continue such coverage;

(b) For an individual employee, the time at which the employee takes full-time employment with another employer; or

(c) Six months after cessation of work by the insured employees. [Formerly 743.527]

**743B.341 Continuation of benefits after termination of group health insurance policy; rules.** (1) Every group health insurance policy that provides coverage for hospital or medical services or expenses shall provide that the insurer shall continue its obligation for benefits under the policy for any person insured under the policy who is hospitalized on the date of termination if the policy is terminated and immediately replaced by a group health insurance policy issued by another insurer. Any payment required under this section is subject to all terms, limitations and conditions of the policy except those relating to termination of benefits. Any obligation by an insurer under this section continues until the hospital confinement ends or hospital benefits under the policy are exhausted, whichever is earlier.

(2) The Director of the Department of Consumer and Business Services may adopt rules providing for uninterrupted coverage for individuals insured under a group health insurance policy providing coverage for hospital or medical expenses, when such a policy is replaced by a policy of similar benefits, whether issued by the same insurer or another. [Formerly 743.529]

**743B.342 Continuation of benefits after injury or illness covered by workers' compensation.** Every policy of group health insurance delivered or issued for delivery in this state shall contain a provision applicable to the coverage for hospital or medical services or expenses provided under the policy that if an employee incurs an injury or illness for which a workers' compensation claim is filed, that policy will continue in effect with respect to that employee upon timely payment by the employee of the premium that includes the individual contribution and the contribution due from the employer under the applicable benefit plan. The employee may maintain such coverage until whichever of the following events first occurs:

(1) The employee takes full-time employment with another employer; or

(2) Six months from the date that the employee first makes payment under this section. [Formerly 743.530]

**743B.343 Availability of continued coverage under group policy for surviving, divorced or separated spouse 55 or older.** (1) A group health insurance policy providing coverage for hospital or medical expenses, other than coverage limited to expenses from accidents or specific diseases, shall contain a provision that:

(a) The surviving spouse of a certificate holder may continue coverage under the policy, at the death of the certificate holder,

with respect to the spouse and any dependent children whose coverage under the policy otherwise would terminate because of the death of the certificate holder if the surviving spouse is 55 years of age or older at the time of the death; and

(b) The divorced or legally separated spouse of a certificate holder may continue coverage under the policy, upon dissolution of marriage with, or legal separation from, the certificate holder, with respect to the divorced or legally separated spouse and any dependent children whose coverage under the policy otherwise would terminate because of the dissolution of marriage or legal separation, if the divorced or legally separated spouse is 55 years of age or older at the time of the dissolution or legal separation.

(2) Continued coverage for dental, vision care or prescription drug expenses shall be offered to legally separated, divorced or surviving spouses and any dependent children eligible under subsection (1) of this section if such coverage is or was available to the certificate holder. [Formerly 743.600]

**743B.344 Procedure for obtaining continuation of coverage under ORS 743B.343.** (1) As used in subsections (1) to (6) of this section, "plan administrator" means:

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

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

(2) Within 60 days of legal separation or the entry of a judgment of dissolution of marriage, a legally separated or divorced spouse eligible for continued coverage under ORS 743B.343 who seeks such coverage shall give the plan administrator written notice of the legal separation or dissolution. The notice shall include the mailing address of the legally separated or divorced spouse.

(3) Within 30 days of the death of a covered person whose surviving spouse is eligible for continued coverage under ORS 743B.343, the group policyholder shall give the plan administrator written notice of the death and of the mailing address of the surviving spouse.

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

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

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

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

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

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

(7) The provisions of this section and ORS 743B.343 and 743B.345 apply only to employers with 20 or more employees and group health insurance plans with 20 or more certificate holders on a typical business day during the preceding calendar year. [Formerly 743.601]

**743B.345 Premium for continuation of coverage under ORS 743B.344; termination of right to continuation.** If a legally separated, divorced or surviving spouse elects continuation of coverage under ORS 743B.344 (1) to (6):

(1) The monthly premium for the continuation shall not be greater than the amount that would be charged if the legally separated, divorced or surviving spouse were a current certificate holder of the group plan plus the amount that the group policyholder would contribute toward the premium if the legally separated, divorced or surviving spouse were a certificate holder of the group plan, plus an additional amount not to exceed two percent of the certificate holder and group plan holder contributions, for the costs of administration.

(2) The first premium shall be paid by the legally separated, divorced or surviving spouse within 45 days of the date of the election.

(3) The right to continuation of coverage shall terminate upon the earliest of any of the following:

(a) The failure to pay premiums when due, including any grace period allowed by the policy;

(b) The date that the group policy is terminated as to all group members except that if a different group policy is made available to group members, the legally separated, divorced or surviving spouse shall be eligible

for continuation of coverage as if the original policy had not been terminated;

(c) The date on which the legally separated, divorced or surviving spouse becomes insured under any other group health plan;

(d) The date on which the legally separated or divorced spouse remarries; or

(e) The date on which the legally separated, divorced or surviving spouse becomes eligible for federal Medicare coverage. [Formerly 743.602]

**743B.347 Continuation of coverage under group policy upon termination of membership in group health insurance policy; applicability of waiting period to rehired employee.** (1) As used in this section:

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

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

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

(b) "Qualified beneficiary" means:

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

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

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

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

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

(C) A covered person becoming eligible for Medicare;

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

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

(F) The death of a covered person.

(2)(a) A grandfathered health plan, as defined in ORS 743B.005, providing coverage under a group health insurance policy for hospital or medical expenses, other than coverage limited to expenses from accidents or specific diseases, must contain a provision that a covered person and any qualified beneficiary may continue coverage under the policy as provided in this section.

(b) A group health insurance policy that provides coverage for one or more of the essential health benefits, other than a grandfathered health plan, must contain a provision that a covered person and any qualified beneficiary may continue coverage under the policy as provided in this section.

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

(a) Medicare; or

(b) The same coverage under any other program that was not covering the covered person or qualified beneficiary on the day before a qualifying event.

(4) The continued coverage must be offered in the same manner as it is provided to other certificate holders under the group health insurance policy.

(5) A covered person or qualified beneficiary must submit a written request for continuation of coverage to the insurer within the time prescribed by the insurer, except that an insurer may not require a request to be submitted less than 10 days after the later of:

(a) The date of a qualifying event; or

(b) The date the insurer provides the notice required by subsection (10) of this section.

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

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

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

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

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

(d) The date that the policy is terminated. However, if the policyholder replaces

the terminated policy with similar coverage under another group health insurance policy:

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

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

(8) A qualified beneficiary who is not eligible for continuation of coverage under ORS 743B.343 may continue coverage under this section upon the dissolution of marriage with or the death of the covered person in the same manner that a covered person may exercise the right to continue coverage under this section.

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

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

(11) This section applies only to employers who are not required to make available continuation of health insurance benefits under Titles X and XXII of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, P.L. 99-272, April 7, 1986. [Formerly 743.610]

## CONTRACTED HEALTH CARE PROVIDERS

**743B.400 Decisions regarding health care facility length of stay, level of care and follow-up care.** (1) All clinical decisions regarding length of stay in a health care facility as defined in ORS 442.015, transfer between levels of care and follow-up care shall be the decision of the treating provider in consultation with the patient, as appropriate.

(2) An insurer may not terminate or restrict the practice privileges of any provider solely on the basis of one or more decisions made pursuant to subsection (1) of this section. [Formerly 743.829]

**743B.403 Insurer prohibited practices; patient communication and referral.** No insurer may terminate or otherwise financially penalize a provider for:

(1) Providing information to or communicating with a patient in a manner that is not slanderous, defamatory or intentionally inaccurate concerning:

(a) Any aspect of the patient's medical condition;

(b) Any proposed treatment or treatment alternatives, whether covered by the insurer's health benefit plan or not; or

(c) The provider's general financial arrangement with the insurer.

(2)(a) Referring a patient to another provider, whether or not that provider is under contract with the insurer. If a provider refers a patient to another provider, the referring provider shall:

(A) Comply with the insurer's written policies and procedures with respect to any such referrals; and

(B) Inform the patient that the referral services may not be covered by the insurer.

(b) Allocation of costs for referral services shall be a matter of contract between the provider and the insurer. Allocation of costs to the provider by contract shall not be considered a penalty under this section. [Formerly 743.834]

**743B.405 Medical services contract provisions; nonprovider party prohibitions; future contracts.** (1) A medical services contract may not require the provider, as an element of the contract or as a condition of compensation for services, to agree:

(a) In the event of alleged improper medical treatment of a patient, to indemnify the other party to the medical services contract for any damages, awards or liabilities including but not limited to judgments, settlements, attorney fees, court costs and any associated charges incurred for any reason other than the negligence or intentional act of the provider or the provider's employees;

(b) To charge the other party to the medical services contract a rate for services rendered pursuant to the medical services contract that is no greater than the lowest rate that the provider charges for the same service to any other person;

(c) To deny care to a patient because of a determination made pursuant to the medical services contract that the care is not covered or is experimental, or to deny referral of a patient to another provider for the provision of such care, if the patient is informed that the patient will be responsible for the payment of such noncovered, experimental or referral care and the patient nonetheless desires to obtain such care or referral; or

(d) Upon the provider's withdrawal from or termination or nonrenewal of the medical services contract, not to treat or solicit a patient even at that patient's request and expense.

(2) A medical services contract shall:

(a) Grant to the provider adequate notice and hearing procedures, or such other procedures as are fair to the provider under the circumstances, prior to termination or nonrenewal of the medical services contract when such termination or nonrenewal is based upon issues relating to the quality of patient care rendered by the provider.

(b) Set forth generally the criteria used by the other party to the medical services contract for the termination or nonrenewal of the medical services contract.

(c) Entitle the provider to an annual accounting accurately summarizing the financial transactions between the parties to the medical services contract for that year.

(d) Allow the provider to withdraw from the care of a patient when, in the professional judgment of the provider, it is in the best interest of the patient to do so.

(e) Provide that a doctor of medicine or doctor of osteopathy licensed under ORS chapter 677 shall be retained by the other party to the medical services contract and shall be responsible for all final medical and mental health decisions relating to coverage or payment made pursuant to the medical services contract.

(f) Provide that a physician, as defined in ORS 677.010, who is practicing in conformity with ORS 677.095 may advocate a decision, policy or practice without being subject to termination or penalty for the sole reason of such advocacy.

(g)(A) Entitle the party to the medical services contract who is being reimbursed for the provision of health care services on a basis that includes financial risk withholds, or the party's representative, to a full accounting of health benefits claims data and related financial information on no less than a quarterly basis by the party to a medical service contract who has made reimbursement, as follows:

(i) The data shall include all pertinent information relating to the health care services provided, including related provider and patient information, reimbursements made and amounts withheld under the financial risk withhold provisions of the medical services contract for the period of time under reconciliation and settlement between the parties.

(ii) Any reconciliation and settlement undertaken pursuant to a medical services contract shall be based directly and exclusively upon data provided to the party who is being reimbursed for the provision of health care services.

(iii) All data, including supplemental information or documentation, necessary to finalize the reconciliation and settlement provisions of a medical services contract relating to financial risk withholds shall be provided to the party who is being reimbursed for the provision of health care services no later than 30 days prior to finalizing the reconciliation and settlement.

(B) Nothing in this paragraph shall be construed to prevent parties to a medical services contract from mutually agreeing to alternative reconciliation and settlement policies and procedures.

(h) Provide that when continuity of care is required to be provided under a health benefit plan by ORS 743B.225, the insurer and the individual provider shall provide continuity of care to enrollees as provided in ORS 743B.225.

(3) The other party to a medical services contract shall not:

(a) Refer to other documents or instruments in a contract unless the nonprovider party agrees to make available to the provider for review a copy of the documents or instruments within 72 hours of request; or

(b) Provide as an element of a contract with a third party relating to the provision of medical services to a patient of the provider that the provider's patient may not sue or otherwise recover from the nonprovider party, or must hold the nonprovider party harmless for, any and all expenses, damages, awards or liabilities that arise from the management decisions, utilization review provisions or other policies or determinations of the nonprovider party that have an impact on the provider's treatment decisions and actions with regard to the patient.

(4) An insurer, independent practice association, medical or mental health clinic or other party to a medical services contract shall provide the criteria for selection of parties to future medical services contracts upon the request of current or prospective parties. [Formerly 743.803]

**Note:** 743B.405, 743B.422 and 743B.424 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 743B. See Preface to Oregon Revised Statutes for further explanation.

**743B.406 Vision care providers.** (1) As used in this section:

(a) "Contractual discount" means a percentage reduction, required under a contract with an insurer, in a vision care provider's usual and customary rate for vision care services and materials.

(b) "Discount card" means a card or other purchasing mechanism or device that is not insurance or a discount medical plan, as defined in ORS 742.420, that purports to offer discounts or access to discounts in health-related purchases from health care providers.

(c) "Materials" includes, but is not limited to:

(A) Lenses;

(B) Devices containing lenses;

(C) Contact lenses;

(D) Prisms;

(E) Lens treatments and contact lens coatings;

(F) Orthopedic or prosthetic devices to correct, relieve or treat defects or abnormal conditions of the human eye or adnexa; and

(G) Vision training.

(d) "Vision care insurance" means a health benefit plan or a policy or certificate of insurance that covers vision care services and materials.

(e) "Vision care provider" includes:

(A) A person licensed to practice optometry under ORS chapter 683; and

(B) A physician licensed under ORS chapter 677 to practice medicine or osteopathy who has completed a residency program in ophthalmology.

(f) "Vision care services" means services provided by a vision care provider within the scope of the provider's license to practice optometry or ophthalmology.

(2) A contract between a vision care provider and an entity that offers vision care insurance or a vision care discount card may not:

(a) Limit or specify the fee that a vision care provider may charge for vision care services or materials that are not reimbursed, in whole or in part, by the vision care insurance or discount card.

(b) Require a vision care provider to participate in one vision care insurance plan or discount card program as a condition for participating in another insurance plan.

(c) Change the terms, the contractual discount or the reimbursement rates, under vision care insurance or a vision care discount card, without a signed acknowledgment that the vision care provider agrees to the changes.

(d) Directly or indirectly restrict or limit a vision care provider's choice of suppliers of materials.

(3) This section does not prohibit the use of a discount card by a patient of a vision care provider if:

(a) The enrollment of the vision care provider is:

(A) Completely voluntary; and

(B) Not conditioned upon the vision care provider's participation in any other discount card program with different provider terms and conditions or in another insurance plan; and

(b) The discount card program does not reimburse the vision care provider for the cost of the vision care services that were discounted. [2015 c.832 §2]

**Note:** 743B.406 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743B or any series therein. See Preface to Oregon Revised Statutes for further explanation.

**743B.407 Naturopathic physicians.** (1) An insurer shall provide a naturopathic physician the choice of applying to be credentialed by the insurer as a primary care provider or as a specialty care provider.

(2) To be credentialed by an insurer as a primary care provider, a naturopathic physician must meet the credentialing requirements as established by the insurer. [2015 c.224 §2]

**Note:** 743B.407 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743B or any series therein. See Preface to Oregon Revised Statutes for further explanation.

## UTILIZATION CONTROLS

**743B.420 Prior authorization requirements.** Except in the case of misrepresentation, prior authorization determinations shall be subject to the following requirements:

(1) Prior authorization determinations relating to benefit coverage and medical necessity shall be binding on the insurer if obtained no more than 30 days prior to the date the service is provided.

(2) Prior authorization determinations relating to enrollee eligibility shall be binding on the insurer if obtained no more than five business days prior to the date the service is provided. [Formerly 743.837]

**743B.422 Utilization review requirements for medical services contracts to which insurer not party; right to appeal.** All utilization review performed pursuant to a medical services contract to which an insurer is not a party shall comply with the following:

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

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

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

(4) A provider request for prior authorization of nonemergency service must be answered within two business days, and qualified health care personnel must be available for same-day telephone responses to inquiries concerning certification of continued length of stay. [Formerly 743.806]

**Note:** See note under 743B.405.

**743B.423 Utilization review requirements for insurers offering health benefit plan.** (1) All insurers offering a health benefit plan in this state that provide utilization review or have utilization review provided on their behalf shall file an annual summary with the Department of Consumer and Business Services that describes all utilization review policies, including delegated utilization review functions, and documents the insurer's procedures for monitoring of utilization review activities.

(2) All utilization review activities conducted pursuant to subsection (1) of this section shall comply with the following:

(a) The criteria used in the utilization review process and the method of development of the criteria shall be made available for review to contracting providers upon request.

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

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

(d) A provider request for prior authorization of nonemergency service must be answered within two business days, and qualified health care personnel must be available for same-day telephone responses to inquiries concerning certification of continued length of stay. [Formerly 743.807]

**743B.424 Applicability.** The provisions of ORS 743B.001, 743B.220, 743B.405 and 743B.422 do not apply to medical services contracts for services to be provided under ORS chapter 656. [Formerly 743.811]

**Note:** See note under 743B.405.

## PAYMENT OF CLAIMS

**743B.450 Prompt payment of claims; limits on use of electronic payment methods; rules.** (1) Except as provided in this subsection, when a claim under a health benefit plan is submitted to an insurer by a provider on behalf of an enrollee, the insurer shall pay a clean claim or deny the claim not later than 30 days after the date on which the insurer receives the claim. If an insurer requires additional information before payment of a claim, not later than 30 days after the date on which the insurer receives the claim, the insurer shall notify the enrollee and the provider in writing and give the enrollee and the provider an explanation of the additional information needed to process the claim. The insurer shall pay a clean claim or deny the claim not later than 30 days after the date on which the insurer receives the additional information.

(2) A contract between an insurer and a provider may not include a provision governing payment of claims that limits the rights and remedies available to a provider under this section and ORS 743B.452 or has the effect of relieving either party of its obligations under this section and ORS 743B.452.

(3) An insurer may pay a claim using a credit card or electronic funds transfer payment method that imposes on the provider a fee or similar charge to process the payment if:

(a) The insurer notifies the provider, in advance, of the fee or other charges associated with the use of the credit card or electronic funds transfer payment method;

(b) The insurer offers the provider an alternative payment method that does not im-

pose fees or similar charges on the provider; and

(c) The provider or a designee of the provider elects to accept a payment of the claim using the payment method.

(4) An insurer shall establish a method of communicating to providers the procedures and information necessary to complete claim forms. The procedures and information must be reasonably accessible to providers.

(5) This section does not create an assignment of payment to a provider.

(6) Each insurer shall report to the Director of the Department of Consumer and Business Services on its compliance under this section according to requirements established by the director.

(7) The director shall adopt by rule a definition of "clean claim" and shall consider the definition of "clean claim" used by the federal Department of Health and Human Services for the payment of Medicare claims. [Formerly 743.911]

**743B.451 Refund of paid claims.** (1) As used in this section, "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, 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 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 provider owes the refund.

(b) 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. [Formerly 743.912]

**Note:** 743B.451 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743B or any series therein. See Preface to Oregon Revised Statutes for further explanation.

**743B.452 Interest on unpaid claims.** (1) An insurer that fails to pay a claim to a provider within the timelines established in ORS 743B.450 shall pay simple interest of 12 percent per annum on the unpaid amount of the claim that is due and owing, accruing from the date after the payment was due until the claim is paid. Interest on any overdue payment for a claim begins to accrue on the 31st day after:

(a) The date on which the insurer received the claim; or

(b) The date the insurer receives the requested additional information.

(2) The interest is payable with the payment of the claim. An insurer is not required to pay interest that is in the amount of $2 or less on any claim.

(3) The availability of interest under subsection (1) of this section is in addition to and not in lieu of administrative actions and penalties that may be imposed by the Director of the Department of Consumer and Business Services under the Insurance Code. [Formerly 743.913]

**743B.453 Underpayment of claims.** (1) Except in the case of fraud and except as provided in subsection (3) of this section, a health care provider may not:

(a) Request additional payment from a health insurer to satisfy a claim unless the provider:

(A) Requests the additional payment in writing on or before the last day of the period specified by the contract or 18 months after the date the claim was denied or payment intended to satisfy the claim was made, whichever is earlier; and

(B) Specifies in the written request why the provider believes the health insurer owes the additional payment.

(b) Request that an additional payment be paid earlier than six months after the health insurer receives the request.

(2) A health insurer may not consider a health care provider's claim untimely if the claim is made no later than 12 months after a different insurer:

(a) Denied the claim in whole or in part; or

(b) Requested a refund of an erroneous payment made on the claim.

(3) A health care provider 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 additional payment from a health insurer to satisfy a claim unless the provider:

(A) Requests the additional payment in writing within 30 months after the date the claim was denied or payment intended to satisfy the claim was made;

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

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

(b) Request that the additional payment be paid earlier than six months after the health insurer receives the request.

(4) 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 insurer from choosing at any time to make additional payments to a health care provider to satisfy a claim.

(5) This section applies to health benefit plans. [Formerly 743.917]

**Note:** 743B.453 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743B or any series therein. See Preface to Oregon Revised Statutes for further explanation.

**743B.454 Claims submitted during credentialing period.** (1) As used in this section:

(a) "Complete application" means a provider's application to a health insurer to become a credentialed provider that includes:

(A) Information required by the health insurer;

(B) Proof that the provider is licensed by a health professional regulatory board as defined in ORS 676.160;

(C) Proof of current registration with the Drug Enforcement Administration of the United States Department of Justice, if applicable to the provider's practice; and

(D) Proof that the provider is covered by a professional liability insurance policy or certification meeting the health insurer's requirements.

(b) "Credentialing period" means the period beginning on the date a health insurer receives a complete application and ending on the date the health insurer approves or rejects the complete application or 90 days after the health insurer receives the complete application, whichever is earlier.

(c) "Health insurer" means an insurer that offers managed health insurance or preferred provider organization insurance, other than a health maintenance organization as defined in ORS 750.005.

(2) A health insurer shall approve or reject a complete application within 90 days of receiving the application.

(3)(a) A health insurer shall pay all claims for medical services covered by the health insurer that are provided by a provider during the credentialing period.

(b) A provider may submit claims for medical services provided during the credentialing period during or after the credentialing period.

(c) A health insurer may pay claims for medical services provided during the credentialing period:

(A) During or after the credentialing period.

(B) At the rate paid to nonparticipating providers.

(d) If a provider submits a claim for medical services provided during the credentialing period within six months after the end of the credentialing period, the health insurer may not deny payment of the claim on the basis of the health insurer's rules relating to timely claims submission.

(4) Subsection (3) of this section does not require a health insurer to pay claims for medical services provided during the credentialing period if:

(a) The provider was previously rejected or terminated as a participating provider in any health benefit plan underwritten or administered by the health insurer;

(b) The rejection or termination was due to the objectively verifiable failure of the provider to provide medical services within the recognized standards of the provider's profession; and

(c) The provider was given the opportunity to contest the rejection or termination before a panel of peers in a proceeding conducted in conformity with the Health Care Quality Improvement Act of 1986, 42 U.S.C. 11101 et seq. [Formerly 743.918]

**Note:** 743B.454 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743B or any series therein. See Preface to Oregon Revised Statutes for further explanation.

**743B.460 Direct payment of hospital and medical services; rate limitations.** (1) A group health insurance policy may on request by the group policyholder provide 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.

(2) Nothing in this section is intended to authorize an insurer to:

(a) Furnish or provide directly services of hospitals or physicians and surgeons; or

(b) Direct, participate in or control the selection of the specific hospital or physician and surgeon from whom the insured secures services or who exercises medical or dental professional judgment.

(3) Nothing in subsection (2) of this section prevents an insurer from negotiating and entering into contracts for alternative rates of payment with providers and offering 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.

(4) Payment so made shall discharge the insurer's obligation with respect to the amount of insurance so paid.

(5) Insurers shall provide group policyholders with a current roster of institutional and professional providers under contract to provide services at alternative rates under their 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. [Formerly 743.531]

**Note:** The amendments to 743B.460 (formerly 743.531) by section 3, chapter 588, Oregon Laws 2015, apply to reimbursement of claims presented on or after January 1, 2017. See section 6, chapter 588, Oregon Laws 2015. The text that applies to claims presented on or after January 1, 2017, is set forth for the user's convenience.

**743B.460.** (1) An insurer may negotiate and enter into contracts for alternative rates of payment with providers to provide services covered by a group health insurance policy and may 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.

(2) Benefits paid by an insurer to a provider under subsection (1) of this section shall discharge the insurer's obligation with respect to the amount of insurance so paid.

(3) Insurers shall provide group policyholders with a current roster of institutional and professional providers under contract to provide services at alternative rates under their 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.

**743B.462 Direct payments to providers.** (1) As used in this section:

(a) "Health benefit plan" has the meaning given that term in ORS 743B.005.

(b) "Provider" means a person licensed, certified or otherwise authorized or permitted by laws of this state to administer medical or mental health services, including substance use disorder services, in the ordinary course of business or practice of a profession.

(2) Except as provided in ORS 743.543 and 743.550, a provider that bills an insurer for covered services provided to an individual who is insured under a health benefit plan or a Medicare supplement insurance policy issued by the insurer shall be reimbursed by the insurer by a direct payment issued to the provider. [2015 c.588 §2]

**Note:** 743B.462 applies to reimbursement of claims presented on or after January 1, 2017. See section 6, chapter 588, Oregon Laws 2015.

**Note:** 743B.462 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743B or any series therein. See Preface to Oregon Revised Statutes for further explanation.

**743B.470 Medicaid not considered in coverage eligibility determination; claims for services paid for by medical assistance; prohibited ground for denial of enrollment of child; insurer duties.** (1) For the purposes of this section:

(a) "Health insurer" or "insurer" means an employee benefit plan, self-insured plan, managed care organization or group health plan, a third party administrator, fiscal intermediary or pharmacy benefit manager of the plan or organization, or other party that is by statute, contract or agreement legally responsible for payment of a claim for a health care item or service.

(b) "Medicaid" means medical assistance provided under 42 U.S.C. 1396a (section 1902 of the Social Security Act).

(2) A health insurer is prohibited from considering the availability or eligibility for medical assistance in this or any other state under Medicaid when considering eligibility for coverage or making payments under its group or individual plan for eligible enrollees, subscribers, policyholders or certificate holders.

(3) To the extent that payment for covered expenses has been made under the state Medicaid program for health care items or services furnished to an individual, in any case when a third party has a legal liability to make payments, the state is considered to have acquired the rights of the individual to payment by any other party for those health care items or services.

(4) An insurer may not deny a claim submitted by the state Medicaid agency, a prepaid managed care health services organization, as defined in ORS 414.025, or a coordinated care organization, as defined in ORS 414.025, under subsection (3) of this section based on the date of submission of the claim, the type or format of the claim form or a failure to present proper documentation at the point of sale that is the basis of the claim if:

(a) The claim is submitted by the agency, the prepaid managed care health services organization or the coordinated care organization within the three-year period beginning on the date on which the health care item or service was furnished; and

(b) Any action by the agency, the prepaid managed care health services organization or the coordinated care organization to enforce its rights with respect to the claim is commenced within six years of the agency's or organization's submission of the claim.

(5) An insurer must provide to the state Medicaid agency, a prepaid managed care health services organization or a coordinated care organization, upon request, the following information:

(a) The period during which a Medicaid recipient, the spouse or dependents may be or may have been covered by the plan;

(b) The nature of coverage that is or was provided by the plan; and

(c) The name, address and identifying numbers of the plan.

(6) An insurer may not deny enrollment of a child under the group or individual health plan of the child's parent on the ground that:

(a) The child was born out of wedlock;

(b) The child is not claimed as a dependent on the parent's federal tax return; or

(c) The child does not reside with the child's parent or in the insurer's service area.

(7) When a child has group or individual health coverage through an insurer of a noncustodial parent, the insurer must:

(a) Provide such information to the custodial parent as may be necessary for the child to obtain benefits through that coverage;

(b) Permit the custodial parent or the provider, with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent; and

(c) Make payments on claims submitted in accordance with paragraph (b) of this subsection directly to the custodial parent, the provider or, if a claim is filed by the state Medicaid agency, a prepaid managed care health services organization or a coordinated care organization, directly to the agency or the organization.

(8) When a parent is required by a court or administrative order to provide health coverage for a child, and the parent is eligible for family health coverage, the insurer must:

(a) Permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions;

(b) If the parent is enrolled but fails to make application to obtain coverage for the child, enroll the child under family coverage upon application of the child's other parent, the state agency administering the Medicaid program or the state agency administering 42 U.S.C. 651 to 669, the child support enforcement program; and

(c) Not disenroll or eliminate coverage of the child unless the insurer is provided satisfactory written evidence that:

(A) The court or administrative order is no longer in effect; or

(B) The child is or will be enrolled in comparable health coverage through another insurer which will take effect not later than the effective date of disenrollment.

(9) An insurer may not impose requirements on a state agency that has been assigned the rights of an individual eligible for medical assistance under Medicaid and covered for health benefits from the insurer if the requirements are different from requirements applicable to an agent or assignee of any other individual so covered.

(10) The provisions of ORS 743A.001 do not apply to this section. [Formerly 743.847]

**743B.475 Guidelines for coordination of benefits; rules.** The Director of the Department of Consumer and Business Services shall by rule establish guidelines for the coordination of benefits for individual and group health insurance, including:

(1) The procedures by which persons insured under the policies are to be made aware of the existence of a coordination of benefits provision;

(2) The benefits which may be subject to such a provision;

(3) The effect of such a provision on the benefits provided;

(4) Establishment of the order of benefit determination; and

(5) Reasonable claim administration procedures to expedite claim payments. [Formerly 743.552]

**(Temporary provisions relating to primary care payment collaborative)**

**Note:** Sections 1, 3, 4 and 5, chapter 575, Oregon Laws 2015, provide:

**Sec. 1.** (1) As used in this section:

(a) "Carrier" means an insurer that offers a health benefit plan, as defined in ORS 743.730 [renumbered 743B.005].

(b) "Prominent carrier" means:

(A) A carrier with annual premium income at a threshold established by the Department of Consumer and Business Services by rule.

(B) The Public Employees' Benefit Board.

(C) The Oregon Educators Benefit Board.

(2) All prominent carriers shall, and carriers other than prominent carriers may, report to the Department of Consumer and Business Services, no later than December 31, 2015, the proportion of the carrier's total medical expenses that are allocated to primary care.

(3) The department shall share with the Oregon Health Authority the information reported so that the authority may prepare the evaluation and report described in section 2 of this 2015 Act.

(4) The department, in collaboration with the authority, shall adopt rules prescribing the primary care services for which costs must be reported under subsection (2) of this section. [2015 c.575 §1]

**Sec. 3.** No later than February 1, 2016, the Oregon Health Authority and the Department of Consumer and Business Services shall report to the Legislative Assembly, in the manner provided in ORS 192.245:

(1) The percentage of the medical expenses of carriers, coordinated care organizations, the Public Employees' Benefit Board and the Oregon Educators Benefit Board that is allocated to primary care; and

(2) How carriers, coordinated care organizations, the Public Employees' Benefit Board and the Oregon Educators Benefit Board pay for primary care. [2015 c.575 §3]

**Sec. 4.** (1) The Legislative Assembly declares that collaboration among insurers, purchasers and providers of health care to coordinate service delivery systems and develop innovative reimbursement methods in support of integrated and coordinated health care delivery is in the best interest of the public. The Legislative Assembly therefore declares its intent to exempt from state antitrust laws, and to provide immunity from federal antitrust laws through the state action doctrine, the activities specified in section 2 (2) of this 2015 Act, of the participants in the primary care payment reform collaborative, that might otherwise be constrained by such laws.

(2) The Director of the Oregon Health Authority or the director's designee shall engage in state supervision of the primary care payment reform collaborative to ensure that the activities and discussions of the participants in the collaborative are limited to the activities described in section 2 (2) of this 2015 Act.

(3) Groups that include, but are not limited to, health insurance companies, health care centers, hospitals, health service organizations, employers, health care providers, health care facilities, state and local governmental entities and consumers may meet to facilitate the development, implementation and operation of the Primary Care Transformation Initiative in accordance with section 2 of this 2015 Act.

(4) The Oregon Health Authority may conduct a survey of the entities and individuals specified in subsection (3) of this section to assist in the evaluation of the Primary Care Transformation Initiative.

(5) A survey or meeting under subsection (3) or (4) of this section is not a violation of state antitrust laws

and shall be considered state action for purposes of federal antitrust laws through the state action doctrine. [2015 c.575 §4]

**Sec. 5.** Sections 1 to 4 of this 2015 Act are repealed on December 31, 2018. [2015 c.575 §5]

## PROVIDER PANELS

**743B.500 Selling and leasing of provider panels by contracting entity; definitions.** As used in this section and ORS 743B.501 to 743B.503:

(1)(a) "Contracting entity" means any person that contracts directly with a provider for the delivery of health care services or contracts with a third party for the purpose of selling or making available to the third party the provider's health care services or discounted rates or the services or rates of a provider panel under a provider network contract.

(b) "Contracting entity" includes a person under common ownership and control of a contracting entity.

(c) "Contracting entity" does not include:

(A) A managed care organization that is certified under ORS 656.260;

(B) A discount medical plan organization as defined in ORS 742.420;

(C) The state medical assistance program;

(D) An independent practice association; or

(E) A self-funded, employer-sponsored health insurance plan regulated under the Employee Retirement Income Security Act of 1974, as codified and amended at 29 U.S.C. 1001, et seq., or any person that provides only administrative services to the self-funded employer-sponsored health insurance plan.

(2) "Health care services" means the treatment of humans for bodily injury, disablement or death by accidental means or as a result of sickness or childbirth, or in prevention of sickness, but does not include treatment for bodily injury, disablement or occupational diseases incurred as a result of employment.

(3) "Independent practice association" has the meaning given that term in ORS 743B.001.

(4) "Person" has the meaning given that term in ORS 731.116.

(5)(a) "Provider" includes:

(A) A physician as defined in ORS 677.010.

(B) A physician group, independent practice association, physician-controlled organization, hospital organization or other provider organization that contracts with a provider for the purpose of facilitating the provider's participation in a provider network contract.

(C) A person licensed, certified or otherwise authorized or permitted by the laws of this state to administer medical services or mental health services in the ordinary course of business or practice of a profession.

(b) "Provider" does not include a contracting entity.

(6) "Provider network contract" means a contract between a provider and a contracting entity for the provision of health care services to patients other than Medicare enrollees or medical assistance recipients.

(7)(a) "Third party" means a person that enters into a contract with a contracting entity or with another party, other than a provider, for the right to exercise the rights of the contracting entity under a provider network contract.

(b) "Third party" includes any of the following:

(A) A payer that directly reimburses the cost of the delivery of health care services;

(B) A third party administrator or other entity that administers or processes claims on behalf of a payer;

(C) A preferred provider organization or network;

(D) A physician-controlled organization or a hospital organization; or

(E) An entity that is engaged in the electronic transmission of claims between a contracting entity and a payer and does not provide to another party access to the health care services and discounted rates of a provider.

(c) "Third party" does not include:

(A) Entities offering health care services under the same brand pursuant to a brand licensing agreement with the same licenser; or

(B) A self-funded, employer-sponsored health insurance plan regulated under the Employee Retirement Income Security Act of 1974, as codified and amended at 29 U.S.C. 1001, et seq., or any person that provides only administrative services to the self-funded employer-sponsored health insurance plan. [Formerly 743.082]

**Note:** 743B.500, 743B.502 and 743B.503 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 743B or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

**743B.501 Registration of contracting entity.** (1) A contracting entity that does not have a certificate of authority shall register with the Department of Consumer and Business Services as a contracting entity by submitting the following information to the

department in written or electronic form as prescribed by the department along with any fee prescribed by the department:

(a) The official name of the entity and any secondary, alternative or substitute designations.

(b) The mailing address and telephone number of the headquarters of the entity.

(c) The name and telephone number of a representative of the entity who shall serve as the primary contact for the department.

(2) The requirements of this section do not apply to a contracting entity that is under common ownership and control of a contracting entity that is licensed by or has a certificate of authority from the department. [Formerly 743.083]

**Note:** 743B.501 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743B or any series therein. See Preface to Oregon Revised Statutes for further explanation.

**743B.502 Third party contracts for leasing of provider panels; requirements.** (1) A contracting entity or a third party may not contract with another third party to provide access to the health care services and discounted rates of a provider under a provider network contract unless:

(a) The third party contract is specifically authorized by the provider network contract; and

(b) The third party contract obligates the third party to comply with all applicable terms, limitations and conditions of the provider network contract.

(2) A contracting entity that provides access to the health care services and discounted rates of a provider under a provider network contract shall:

(a) Give to the provider in writing or electronically, at the time a provider network contract is entered into, a list of all third parties known by the contracting entity at the time to which the contracting entity has or will provide access to the health care services and discounted rates of a provider under the provider network contract;

(b) Maintain an Internet website, toll-free telephone number or other readily available mechanism through which a provider may obtain a list, updated at least every 90 days, of all third parties that have access to the provider's health care services and discounted rates under the provider network contract;

(c) Provide each third party listed under paragraph (a) or (b) of this subsection with information necessary to enable the third party to comply with all relevant terms, limitations and conditions of the provider network contract;

(d) Require a third party to identify on each remittance or explanation of payment sent to a provider the source of any contractual discount in rates taken by the third party under the provider network contract; and

(e)(A) Notify each third party listed under paragraph (a) or (b) of this subsection of the termination of the provider network contract no later than 30 days prior to the effective date of the termination; and

(B) Require third parties to cease claiming entitlement to discounted rates or other rights under a provider network contract after the termination of the contract.

(3) The notice required under subsection (2)(e)(A) of this section can be provided by any reasonable means, including but not limited to written notice, electronic communication or an update to an electronic database.

(4) Subject to any applicable continuity of care requirements, agreements or contractual provisions:

(a) A third party's right to access a provider's health care services and discounted rates under a provider network contract shall terminate on the date the provider network contract is terminated;

(b) Claims for health care services performed after the termination date of the provider network contract are not eligible for processing and payment in accordance with the provider network contract; and

(c) Claims for health care services performed before the termination date of the provider network contract, but processed after the termination date, are eligible for processing and payment in accordance with the provider network contract.

(5)(a) All information made available to a provider in accordance with the requirements of this section and ORS 743B.503 shall be confidential and may not be disclosed to any person not involved in the provider's practice or the administration thereof without the prior written consent of the contracting entity.

(b) This section and ORS 743B.503 may not be construed to prohibit a contracting entity from requiring a provider to execute a reasonable confidentiality agreement to ensure that confidential or proprietary information disclosed by the contracting entity is not used for any purpose other than the provider's direct practice management or billing activities. [Formerly 743.085]

**Note:** See note under 743B.500.

**743B.503 Additional requirements for third party contracts.** (1) A contract between a third party and a contracting entity

or between two third parties with respect to a provider network contract must comply with this section and ORS 743B.502.

(2)(a) A third party shall inform the contracting entity and providers under a contracting entity's provider network contract of a website, toll-free number or other readily available mechanism to identify the names of all third parties to which the third party provides access to the health care services and discounted rates of a provider under the provider network contract.

(b) The third party shall update the website described in paragraph (a) of this subsection at least every 90 days to reflect all third parties currently provided access. Upon request, the third party shall make the information available to a provider via telephone or through direct notification.

(3) A provider may refuse to accept as payment in full a discounted payment made by a third party under the terms of a provider network contract if there is no valid contractual basis for the discount or the discount is taken in violation of this section or ORS 743B.502. [Formerly 743.086]

**Note:** See note under 743B.500.

**743B.505 Provider networks; rules.** (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. [2015 c.59 §2]

**Note:** 743B.505 becomes operative January 1, 2017. See section 11, chapter 59, Oregon Laws 2015.

**Note:** 743B.505 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743B or any series therein. See Preface to Oregon Revised Statutes for further explanation.

## DISCLOSURE OF HEALTH INFORMATION

**743B.550 Disclosure of information.** Nothing in ORS 743.008, 743A.012, 743B.195 to 743B.206, 743B.250, 743B.400, 743B.403, 743B.420, 743B.423 and 743B.550 shall be construed to require disclosure of information that is otherwise privileged or confidential under any other provision of law. [Formerly 743.839]

**743B.555 Confidential communications.** (1) As used in this section:

(a) "Carrier" has the meaning given that term in ORS 743B.005.

(b) "Communication" includes:

(A) An explanation of benefits notice;

(B) Information about an appointment;

(C) A notice of an adverse benefit determination;

(D) A carrier's or third party administrator's request for additional information regarding a claim;

(E) A notice of a contested claim;

(F) The name and address of a provider, a description of services provided and other visit information; and

(G) Any written, oral or electronic communication described in this paragraph from a carrier or a third party administrator to a policyholder, certificate holder or enrollee that contains protected health information.

(c) "Confidential communications request" means a request from an enrollee to a carrier or third party administrator that communications be sent directly to the enrollee and that the carrier or third party administrator refrain from sending communications concerning the enrollee to the policyholder or certificate holder.

(d) "Protected health information" has the meaning given that term in ORS 192.556.

(2) A carrier and a third party administrator doing business in this state:

(a) Shall permit any enrollee to submit a confidential communications request.

(b) Shall update an enrollee on the status of implementing a confidential communications request upon the enrollee's inquiry.

(3) The procedure adopted by a carrier or third party administrator for enrollees to make confidential communications requests:

(a) Must allow enrollees to use the form described in subsection (4) of this section and may also allow enrollees to make the request by other means such as telephone or the Internet.

(b) Shall ensure that the confidential communications request remains in effect until the enrollee revokes the request in writing or submits a new confidential communications request.

(c) Shall ensure that the confidential communications request is acted upon and implemented by the carrier or third party administrator not later than seven days after receipt of a request by electronic means or 30 days after receipt of a request in hard copy.

(d) May not require an enrollee to waive any right to limit disclosure under this section as a condition of eligibility for or coverage under a health benefit plan.

(e) Must be easy to understand and to complete.

(4) The Department of Consumer and Business Services shall work with stakeholders to develop and make available to the public a standardized form that an enrollee may submit to a carrier or third party administrator to make a confidential communications request. The department may encourage health care providers to clearly display the form and make it available to patients. At a minimum, the form must:

(a) Inform an enrollee about the enrollee's right to have protected health information sent to the enrollee and not disclosed to the policyholder or certificate holder;

(b) Allow an enrollee to indicate where to redirect communications containing protected health information, including a specified mail or electronic mail address or specified telephone number;

(c) Allow an enrollee to designate a mail or electronic mail address or telephone number for the carrier or third party administra-

tor to contact the enrollee if additional information or clarification is necessary to process the confidential communications request; and

(d) Include a disclaimer that it may take up to 30 days from the date of receipt for a carrier or third party administrator to process the form.

(5) If an insurer makes an adverse benefit determination regarding a claim concerning health care provided to an enrollee who has made a confidential communications request:

(a) The enrollee has the right to appeal the determination; and

(b) The policyholder or certificate holder may not appeal the adverse benefit determination unless the enrollee has signed an authorization to disclose claims information relevant to the appeal.

(6) As used in this section, "enrollee" does not include an individual who is in the custody of the Department of Corrections.

(7) The department shall interpret this section in a manner that is consistent with federal law. [2015 c.470 §2]

**Note:** 743B.555 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743B or any series therein. See Preface to Oregon Revised Statutes for further explanation.

**Note:** Section 3, chapter 470, Oregon Laws 2015, provides:

**Sec. 3.** (1) No later than December 1, 2016, the Department of Consumer and Business Services shall report, in the manner prescribed by ORS 192.245, on:

(a) The effectiveness of the process described in section 2 of this 2015 Act [743B.555] in allowing health insurance enrollees to redirect insurance communications containing protected health information, the extent to which enrollees are using the process and whether the process is working properly; and

(b) The education and outreach activities conducted by carriers or third party administrators to inform Oregonians about their right to have protected health information redirected.

(2) The department shall require carriers or third party administrators to report data necessary for the department to produce the report described in subsection (1) of this section. [2015 c.470 §3]

## PRESCRIPTION DRUG COVERAGE

**743B.601 Synchronization of prescription drug refills.** (1) As used in this section:

(a) "Health plan" means:

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

(B) A self-insured health plan offered by the Public Employees' Benefit Board, the Oregon Educators Benefit Board or the Oregon Health and Science University.

(b) "Synchronization policy" means a procedure for aligning the refill dates of a patient's prescription drugs so that drugs that are refilled at the same frequency may be refilled concurrently.

(2) A health plan that includes prescription drug coverage must implement a synchronization policy for the dispensing of prescription drugs to the plan's enrollees. [2014 c.25 §2]

**Note:** The amendments to 743B.601 by section 1, chapter 800, Oregon Laws 2015, apply to health plans issued or renewed on or after January 1, 2017. See section 3, chapter 800, Oregon Laws 2015. The text that applies to health plans issued or renewed on or after January 1, 2017, is set forth for the user's convenience.

**743B.601.** (1) As used in this section:

(a) "Health plan" means:

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

(B) A self-insured health plan offered by the Public Employees' Benefit Board, the Oregon Educators Benefit Board or the Oregon Health and Science University.

(b) "Synchronization policy" means a procedure for aligning the refill dates of a patient's prescription drugs so that drugs that are refilled at the same frequency may be refilled concurrently.

(2) A health plan that includes prescription drug coverage shall implement a synchronization policy for the dispensing of prescription drugs to the plan's enrollees.

(3) A health plan shall reimburse the cost of prescription drugs dispensed in accordance with the plan's synchronization policy.

(4) If a drug is dispensed in less than a 30-day supply for the purpose of synchronizing a patient's prescription drug refills, a health plan shall:

(a) Prorate the copayment; or

(b) Adjust the copayment using a method approved by the Department of Consumer and Business Services.

(5) A health plan shall fully reimburse the dispensing fee for partially filled or refilled prescription drugs.

(6) This section does not apply to prescription drugs that:

(a) Are in unit-of-use packaging for which synchronization is not possible;

(b) Are controlled substances; or

(c) Have been identified by the United States Drug Enforcement Administration as having a high risk of diversion.

(7) The coverage required by this section may be limited by formulary restrictions applied to a prescription drug by a health plan.

(8)(a) This section does not apply to a prepaid group practice health plan with at least 200,000 enrollees in this state.

(b) As used in this subsection, "prepaid group practice health plan" means a health care service contractor that provides physician services to its enrollees through an integrated health care delivery system using, primarily, a single group of physicians contracted on a prepaid, capitated basis.

**Note:** 743B.601 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743B or any series therein. See Preface to Oregon Revised Statutes for further explanation.

**743B.602 Step therapy.** (1) As used in this section:

(a) "Health care coverage plan" includes:

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

(B) An insurance policy or certificate covering the cost of prescription drugs, hospital expenses, health care services and medical expenses, equipment and supplies;

(C) A medical services contract, as defined in ORS 743B.001;

(D) A multiple employer welfare arrangement, as defined in ORS 750.301;

(E) A contract or agreement with a health care service contractor, as defined in ORS 750.005, or a preferred provider organization;

(F) A pharmacy benefit manager, as defined in ORS 735.530, or other third party administrator that pays prescription drug claims; and

(G) An accident insurance policy or any other insurance contract providing reimbursement for the cost of prescription drugs, hospital expenses, health care services and medical expenses, equipment and supplies.

(b) "Step therapy" means a drug protocol in which a health care coverage plan will reimburse the cost of a prescribed drug only if the patient has first tried a specified drug or series of drugs.

(2) A health care coverage plan that requires step therapy shall make easily accessible to prescribing practitioners, clear explanations of:

(a) The clinical criteria for each step therapy protocol;

(b) The procedure by which a practitioner may submit to the plan the practitioner's medical rationale for determining that a particular step therapy protocol is not appropriate for a particular patient based on the patient's medical condition and history; and

(c) The documentation, if any, that a practitioner must submit to the plan for the plan to determine the appropriateness of step therapy for a specific patient. [2014 c.55 §4]

**Note:** 743B.602 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743B or any series therein. See Preface to Oregon Revised Statutes for further explanation.

## MISCELLANEOUS

**743B.800 Risk adjustment procedures; rules.** (1) As used in this section, "health benefit plan" means a health benefit plan, as defined in ORS 743B.005, that is offered in the individual or small group market.

(2) The Department of Consumer and Business Services may establish by rule a procedure for adjusting risk between insurers. If a procedure is established, the procedure may include:

(a) An assessment imposed on an insurer if the actuarial risk of the enrollees in the insurer's health benefit plans is less than the average actuarial risk of all enrollees in all health benefit plans in this state; and

(b) Payments to insurers if the actuarial risk of the enrollees in the insurer's health benefit plans is greater than the average actuarial risk of all enrollees in all health benefit plans in this state.

(3) A procedure established under this section must be consistent with 42 U.S.C. 18063 and regulations adopted by the Secretary of the United States Department of Health and Human Services to carry out 42 U.S.C. 18063. [Formerly 743.923]

**Note:** 743B.800 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743B or any series therein. See Preface to Oregon Revised Statutes for further explanation.

**743B.810 Enrollees covered by workers' compensation.** (1) A health benefit plan may not exclude, and shall expedite preauthorizations required for, work-related injuries or occupational diseases if:

(a) The injured worker is covered by workers' compensation insurance and the health benefit plan; and

(b) The injured worker has submitted a workers' compensation claim for the work-related injury or occupational disease that has not been accepted or denied by the workers' compensation carrier.

(2) A health benefit plan subject to this section shall guarantee payment for preauthorized medical services to the provider of those medical services according to the terms, conditions and benefits of the plan if the claim is found not to be a compensable workers' compensation claim.

(3) As used in this section, "health benefit plan" has the meaning given that term in ORS 743B.005 and also means self-insured benefit plans and health benefit plans provided by the Oregon Educators Benefit Board and the Public Employees' Benefit Board.

(4) The provisions of ORS 743A.001 do not apply to this section. [2014 c.94 §2]

**Note:** 743B.810 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743B or any series therein. See Preface to Oregon Revised Statutes for further explanation.