Enrolled
House Bill 3040

Sponsored by Representatives KRUSE, KRUMMEL; Representatives BACKLUND, BARNHART, BATES, BROWN, BUTLER, CARLSON, DEVLIN, DOYLE, GARRARD, HASS, KNOPP, KRIEGER, LEE, LOWE, MERKLEY, MINNIS, MONNES ANDERSON, MORGAN, MORRISETTE, NELSON, NOLAN, PATRIDGE, RINGO, ROSENBAUM, SHETTERLY, G SMITH, P SMITH, T SMITH, STARR, TOMEI, C WALKER, V WALKER, WILSON, WINTERS, WIRTH, WITT, ZAUNER, Senators CASTILLO, CORCORAN, METSGER

CHAPTER .....

AN ACT

Relating to protections for enrollees of health benefit plans; creating new provisions; and amending ORS 743.801, 743.803, 743.804, 743.817, 746.075, 750.055 and 750.333.

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

SECTION 1. ORS 743.801 is amended to read:

743.801. As used in ORS 743.699, 743.801, 743.803, 743.804, 743.806, 743.807, 743.808, 743.809, 743.811, 743.814, 743.817, 743.819, 743.821, 743.823, 743.827, 743.829, 743.831, 743.834, 743.837 and 743.839 **and sections 3, 5, 8, 9, 10, 11, 12, 13 and 14 of this 2001 Act**:

(1) "Emergency medical condition" means a medical condition that manifests itself by symptoms of sufficient severity that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus in the case of a pregnant woman, in serious jeopardy.

(2) "Emergency medical screening exam" means the medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an emergency medical condition.

(3) "Emergency services" means those health care items and services furnished in an emergency department and all ancillary services routinely available to an emergency department to the extent they are required for the stabilization of a patient.

(4) "Enrollee" has the meaning given that term in ORS 743.730.

[*(4)*] **(5)** "Grievance" means a written complaint submitted by or on behalf of an enrollee regarding the:

(a) Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(b) Claims payment, handling or reimbursement for health care services; or

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

[*(5)*] **(6)** "Health benefit plan" has the meaning provided for that term in ORS 743.730.

[*(6)*] **(7)** "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 743.522, to provide health care services to group members.

[*(7)*] **(8)** "Insurer" has the meaning provided for that term in ORS 731.106. For purposes of ORS 743.699, 743.801, 743.803, 743.804, 743.806, 743.807, 743.808, 743.809, 743.811, 743.814, 743.817, 743.819, 743.821, 743.823, 743.827, 743.829, 743.831, 743.834, 743.837, 743.839, 750.055 and 750.333 **and sections 3, 5, 8, 9, 10, 11, 12, 13 and 14 of this 2001 Act**, "insurer" also includes a health care service contractor as defined in ORS 750.005.

[*(8)*] **(9)** "Managed health insurance" means any health benefit plan that:

(a) Requires an enrollee to use[*, or creates incentives for an enrollee to use,*] **a specified network of 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**; [*and*] **or**

(b) [*Reimburses any of the providers described in paragraph (a) of this subsection on a basis other than fee-for-service billing or discounts from fee-for-service billing.*] **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.**

[*(9)*] **(10)** "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.

(11)(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.

[*(10)*] **(12)** "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.

[*(11)*] **(13)** "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.

[*(12)*] **(14)** "Stabilization" means that, within reasonable medical probability, no material deterioration of an emergency medical condition is likely to occur.

[*(13)*] **(15)** "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.

SECTION 2. Sections 3, 5, 8, 9, 10, 11, 12, 13 and 14 of this 2001 Act are added to and made a part of ORS chapter 743.

CONTINUITY OF CARE

SECTION 3. (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 termi-

nation 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.

SECTION 4. ORS 743.803 is amended to read:

743.803. (1) [*No*] **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) [*All*] **A** medical services [*contracts*] **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 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 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 section 3 of this 2001 Act, the insurer and the individual provider shall provide continuity of care to enrollees as provided in section 3 of this 2001 Act.

(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.

REFERRALS TO SPECIALISTS

SECTION 5. (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.

NETWORK ADEQUACY

SECTION 6. ORS 743.817 is amended to read:

743.817. [*All insurers*] **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 [*documents*] **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.

SECTION 7. ORS 746.075 is amended to read:

746.075. **(1) A person may not engage, directly or indirectly, in any action described in subsection (2) of this section in connection with:**

(a) [*In*] The offer or sale of any insurance[*, directly or indirectly,*]**;** or

(b) [*In connection with*] Any inducement or attempted inducement[*, directly or indirectly*,] of any insured or person with ownership rights under an issued life insurance policy to lapse, forfeit, surrender, assign, effect a loan against, retain, exchange or convert the policy[*, no person shall:*]**.**

(2) Subsection (1) of this section applies to the following actions:

[*(1)*] **(a)** [*Make, issue, circulate or cause*] **Making, issuing, circulating or causing** to be made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages therein or the dividends or share of surplus to be received thereon;

[*(2)*] **(b)** [*Make*] **Making** any false or misleading representation as to the dividends or share of surplus previously paid on similar policies;

[*(3)*] **(c)** [*Make*] **Making** any false or misleading representation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates;

[*(4)*] **(d)** [*Use*] **Using** any name or title of any policy or class of policies misrepresenting the true nature thereof;

[*(5)*] **(e)** [*Employ*] **Employing** any device, scheme[,] or artifice to defraud;

[*(6)*] **(f)** [*Obtain*] **Obtaining** money or property by means of any untrue statement of a material fact or any omission to state a material fact necessary in order to make the statement [*made*], in light of the circumstances under which it was made, not misleading; [*or*]

[*(7)*] **(g)** [*Engage*] **Engaging** in any other transaction, practice or course of business [*which*] **that** operates as a fraud or deceit upon the purchaser, insured or person with policy ownership rights[.]**; or**

(h) Materially misrepresenting the provider network of an insurer offering managed health insurance or preferred provider organization insurance as defined in ORS 743.801, including its composition and the availability of its providers to enrollees in the plan.

EXTERNAL REVIEW

SECTION 8. (1) An insurer offering health benefit plans in this state shall have an external review program that meets the requirements of this section and sections 10 and 11 of this 2001 Act. Each insurer shall provide the external review through an independent review organization that is under contract with the Director of the Department of Consumer and Business Services to provide external review. Each health benefit plan must allow an enrollee, by applying to the insurer, to obtain review by an independent review organization of a dispute relating to an adverse decision 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 section 3 of this 2001 Act.

(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 insurer shall request the director to 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 and shall produce additional information as requested by the independent review organization to the extent that the information is reasonably available to the insurer. The insurer shall furnish all such records, materials and information in a timely manner in order to enable a timely decision by the independent review organization. The director may establish timelines for the purpose of this subsection.

(4) An insurer shall expedite an enrollee's case 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.

SECTION 9. (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 section 8 of this 2001 Act. 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.

SECTION 10. (1) An insurer of a health benefit plan shall include in the plan the following statements, in boldfaced type or otherwise emphasized:

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

(b) A statement of whether the insurer agrees to be bound by decisions of independent review organizations.

(2) If an insurer states in the health benefit plan as provided in subsection (1) of this section that the insurer is not bound by the decisions of independent review organizations, the plan and the written information provided by the plan must prominently disclose that:

(a) The insurer is not bound by the decisions of independent review organizations;

(b) The insurer may follow nonetheless a decision by an independent review organization; and

(c) If the insurer does not follow a decision of an independent review organization, the enrollee has the right to sue the insurer.

(3) If an insurer states in the health benefit plan as provided in subsection (1) of this section that the insurer is bound by the decisions of independent review organizations, the plan must prominently disclose that fact. The plan must also state that the insurer agrees to act in accordance with the decision of the independent review organization notwithstanding the definition of medical necessity in the plan.

SECTION 11. (1) An enrollee shall apply in writing for external review of an adverse decision 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 internal review through its grievance and appeal process under ORS 743.804. 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 grievance procedures established pursuant to ORS 743.804. The insurer may waive the requirement of compliance with the internal grievance procedures and have a dispute referred directly to external review upon the enrollee's consent.

(2) An enrollee who applies for external review of an adverse decision shall provide complete and accurate information to the independent review organization in a timely manner.

SECTION 12. (1) An independent review organization shall perform the following duties when appointed under section 8 of this 2001 Act to review a dispute under a health benefit plan between an insurer and an enrollee:

(a) Decide whether the dispute is covered by the conditions established in section 8 of this 2001 Act for external review 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 Director of the Department of Consumer and Business Services and the availability of other assistance as specified by the director.

(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.

(d) Notify the insurer of additional information the independent review organization requires and when the information must be submitted.

(e) Decide the dispute relating to the adverse decision of the insurer under section 8 (1) of this 2001 Act 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.

(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.

(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.

SECTION 13. (1) If an insurer has agreed under the provisions of a health benefit plan to be bound by the decision of an independent review organization and the insurer fails to comply with such a decision, the Director of the Department of Consumer and Business

Services shall impose on the insurer a civil penalty of not less than $100,000 and 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.

SECTION 14. (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 decision by the insurer that is subject to external review if:

(a) The insurer states in the health benefit plan in which the enrollee is enrolled that the insurer is not bound by the decisions of an independent review organization; and

(b) 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 either subsection (1)(a) or (b) of this section to be unconstitutional or otherwise void.

SECTION 15. ORS 743.804 is amended to read:

743.804. All insurers offering a health benefit plan in this state shall:

(1) Have a written policy that recognizes the rights of enrollees:

(a) To voice grievances about the organization or health care provided;

(b) To be provided with information about the organization, its services and the providers providing care;

(c) To participate in decision making regarding their health care; and

(d) To be treated with respect and recognition of their dignity and need for privacy.

(2) Provide a summary of policies on enrollees' rights and responsibilities to all participating providers upon request and to all enrollees either directly or, in the case of group coverage, to the employer or other policyholder for distribution to enrollees.

(3) Have a timely and organized system for resolving grievances and appeals. The system shall include:

(a) A systematic method for recording all grievances and appeals, including the nature of the grievances, and significant actions taken;

(b) Written procedures explaining the grievance and appeal process, including a procedure to assist enrollees in filing written grievances;

(c) Written decisions in plain language justifying grievance determinations, including appropriate references to relevant policies, procedures and contract terms;

(d) Standards for timeliness in responding to grievances or appeals that accommodate the clinical urgency of the situation;

(e) Notice in all written decisions prepared pursuant to this subsection that the enrollee may file a complaint with the Director of the Department of Consumer and Business Services; and

(f) An appeal process for grievances that includes at least the following:

(A) [*Two*] **Three** levels of review, the second of which shall be by persons not previously involved in the dispute **and the third of which shall provide external review pursuant to an external review program meeting the requirements of sections 8, 10 and 11 of this 2001 Act**;

(B) Opportunity for enrollees and any representatives of the enrollees to appear before a review panel at either the first or second level of review. Representatives may include health care providers or any other persons chosen by the enrollee. The enrollee and insurer shall each provide advance notification of the number of representatives who will appear before the panel and the relationship of the representatives to the enrollee or insurer; and

(C) Written decisions in plain language justifying appeal determinations, including specific references to relevant provisions of the health benefit plan and related written corporate practices.

(4) If the insurer has a prescription drug formulary, have:

(a) A written procedure by which a provider with authority to prescribe drugs and medications may prescribe drugs and medications not included in the formulary. The procedure shall include the circumstances when a drug or medication not included in the formulary will be considered a covered benefit; and

(b) A written procedure to provide full disclosure to enrollees of any cost sharing or other requirements to obtain drugs and medications not included in the formulary.

(5) Furnish to all enrollees either directly or, in the case of a group policy, to the employer or other policyholder for distribution to enrollees written general information informing enrollees about services provided, access to services, charges and scheduling applicable to each enrollee's coverage, including:

(a) Benefits and services included and how to obtain them, including any restrictions that apply to services obtained outside the insurer's network or outside the insurer's service area**, and the availability of continuity of care as required by section 3 of this 2001 Act**;

(b) Provisions for referrals, if any, for specialty care, behavioral health services and hospital services and how enrollees may obtain the care or services;

(c) Provisions for after-hours and emergency care and how enrollees may obtain that care, including the insurer's policy, if any, on when enrollees should directly access emergency care and use 9-1-1 services;

(d) Charges to enrollees, if applicable, including any policy on cost sharing for which the enrollee is responsible;

(e) Procedures for notifying enrollees of:

(A) A change in or termination of any benefit;

(B) If applicable, termination of a primary care delivery office or site; and

(C) If applicable, assistance available to enrollees affected by the termination of a primary care delivery office or site in selecting a new primary care delivery office or site;

(f) Procedures for appealing decisions adversely affecting the enrollee's benefits or enrollment status;

(g) Procedures, if any, for changing providers;

(h) Procedures for voicing grievances**, including the option of obtaining external review under the insurer's program established pursuant to sections 8, 10 and 11 of this 2001 Act**;

(i) A description of the procedures, if any, by which enrollees and their representatives may participate in the development of the insurer's corporate policies and practices;

(j) Summary information on how the insurer makes decisions regarding coverage and payment for treatment or services, including a general description of any prior authorization and utilization review requirements that affect coverage or payment;

(k) A summary of criteria used to determine if a service or drug is considered experimental or investigational;

(L) Information about provider, clinic and hospital networks, if any, including a list of network providers and information about how the enrollee may obtain current information about the availability of individual providers, the hours the providers are available and a description of any limitations on the ability of enrollees to select primary and specialty care providers;

(m) A general disclosure of any risk-sharing arrangements the insurer has with physicians and other providers;

(n) A summary of the insurer's procedures for protecting the confidentiality of medical records and other enrollee information, including the provision required in ORS 743.809;

(o) A description of any assistance provided to non-English-speaking enrollees;

(p) A summary of the insurer's policies, if any, on drug prescriptions, including any drug formularies, cost sharing differentials or other restrictions that affect coverage of drug prescriptions;

(q) Notice of the enrollee's right to file a complaint or seek other assistance from the Director of the Department of Consumer and Business Services; and

(r) Notice of the information that is available upon request pursuant to subsection (6) of this section and information that is available from the Department of Consumer and Business Services pursuant to ORS 743.804, 743.807, 743.814 and 743.817.

(6) Provide the following information upon the request of an enrollee or prospective enrollee:

(a) Rules related to the insurer's drug formulary, if any, including information on whether a particular drug is included or excluded from the formulary;

(b) Provisions for referrals, if any, for specialty care, behavioral health services and hospital services and how enrollees may obtain the care or services;

(c) A copy of the insurer's annual report on grievances and appeals as submitted to the department under subsection (9) of this section;

(d) A description of the insurer's risk-sharing arrangements with physicians and other providers consistent with risk-sharing information required by the federal Health Care Financing Administration pursuant to 42 CFR 417.124 (3) (b) as in effect on June 18, 1997;

(e) A description of the insurer's efforts, if any, to monitor and improve the quality of health services; [*and*]

(f) Information about any insurer procedures for credentialing network providers and how to obtain the names, qualifications and titles of the providers responsible for an enrollee's care[.]**; and**

(g) A description of the insurer's external review program established pursuant to sections 8, 10 and 11 of this 2001 Act.

(7) Except as otherwise provided in this subsection, provide to enrollees, upon request, 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 section shall require an insurer to advise an enrollee how the insurer would cover or treat that particular enrollee's disease or condition. Utilization review criteria that is proprietary shall be subject to verbal disclosure only.

(8) Provide the following information to an enrollee when the enrollee has filed a grievance:

(a) Detailed information on the insurer's grievance and appeal procedures and how to use them; [*and*]

(b) Information on how to access the complaint line of the Department of Consumer and Business Services[.]**; and**

(c) Information explaining how an enrollee applies for external review of the insurer's actions under the external review program established by the insurer pursuant to section 8 of this 2001 Act.

(9) Provide annual summaries to the Department **of Consumer and Business Services** of the insurer's aggregate data regarding grievances**,** [*and*] appeals **and applications for external review** in a format prescribed by the department to ensure consistent reporting on the number, nature and disposition of grievances**,** [*and*] appeals **and applications for external review**.

(10) Ensure that the confidentiality of specified patient information and records is protected, and to that end:

(a) Adopt and implement written confidentiality policies and procedures;

(b) State the insurer's expectations about the confidentiality of enrollee information and records in medical service contracts; and

(c) Afford enrollees the opportunity to approve or deny the release of identifiable medical personal information by the insurer, except as otherwise required by law.

(11) Notify an enrollee of the enrollee's rights under the health benefit plan at the time that the insurer notifies the enrollee of an adverse decision. The notification shall include:

(a) Notice of the right of the enrollee to apply for internal and external review of the adverse decision;

(b) A statement whether a decision by an independent review organization is binding on the insurer and enrollee;

(c) A statement that if the decision is not binding on the insurer and if the insurer does not comply with the decision, the enrollee may sue the insurer as provided in section 14 of this 2001 Act; and

(d) Information on filing a complaint with the Director of the Department of Consumer and Business Services.

SECTION 16. ORS 750.055 is amended to read:

750.055. (1) The following provisions of the Insurance Code shall apply to health care service contractors to the extent so applicable and not inconsistent with the express provisions of ORS 750.005 to 750.095:

(a) ORS 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398 to 731.430, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.737, 731.740, 731.750, 731.804 and 731.844 to 731.992.

(b) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.592, not including ORS 732.549 and 732.574 to 732.592.

(c)(A) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.620, 733.635 to 733.680 and 733.695 to 733.780 apply to not-for-profit health care service contractors.

(B) ORS chapter 733, not including ORS 733.630, applies to for-profit health care service contractors.

(d) ORS chapter 734.

(e) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to 742.540, 743.010, 743.013, 743.018 to 743.030, 743.050, 743.100 to 743.109, 743.402, 743.412, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.527, 743.528, 743.529, 743.549 to 743.555, 743.556, 743.560, 743.600 to 743.610, 743.650 to 743.656, 743.693, 743.697, 743.699, 743.701, 743.704, 743.706 to 743.712, 743.721, 743.722, 743.726, 743.727, 743.728, 743.729, 743.804, 743.807, 743.808, 743.809, 743.814 to 743.839, 743.842, 743.845 and 743.847 **and sections 3, 5, 8, 9, 10, 11, 12, 13 and 14 of this 2001 Act**.

(f) The provisions of ORS chapter 744 relating to the regulation of agents.

(g) ORS 746.005 to 746.140, 746.160, 746.180, 746.220 to 746.370 and 746.600 to 746.690.

(h) ORS 743.714, except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act unless the patient is referred by a physician associated with a group practice health maintenance organization.

(i) ORS 735.600 to 735.650.

(j) ORS 743.680 to 743.689.

(k) ORS 744.700 to 744.740.

(L) ORS 743.730 to 743.773.

(m) ORS 731.485, except in the case of a group practice health maintenance organization that is federally qualified pursuant to Title XIII of the Public Health Service Act and that wholly owns and operates an in-house drug outlet.

(2) For the purposes of this section only, health care service contractors shall be deemed insurers.

(3) Any for-profit health care service contractor organized under the laws of any other state which is not governed by the insurance laws of such state, will be subject to all requirements of ORS chapter 732.

(4) The Director of the Department of Consumer and Business Services may, after notice and hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025 and 750.045 that are deemed necessary for the proper administration of these provisions.

SECTION 17. ORS 750.333 is amended to read:

750.333. (1) The following provisions of the Insurance Code apply to trusts carrying out a multiple employer welfare arrangement:

(a) ORS 731.004 to 731.150, 731.162, 731.216 to 731.268, 731.296 to 731.316, 731.324, 731.328, 731.378, 731.386, 731.390, 731.398, 731.406, 731.410, 731.414, 731.418 to 731.434, 731.454, 731.484, 731.486, 731.488, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.804 to 731.992.

(b) ORS 733.010 to 733.050, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

(c) ORS chapter 734.

(d) ORS 742.001 to 742.009, 742.013, 742.061 and 742.400.

(e) ORS 743.028, 743.053, 743.524, 743.526, 743.527, 743.528, 743.529, 743.530, 743.560, 743.562, 743.600, 743.601, 743.602, 743.610, 743.693, 743.699, 743.727, 743.728, 743.730 to 743.773 (except 743.760 to 743.773), 743.801, 743.804, 743.807, 743.808, 743.809, 743.814 to 743.839, 743.842, 743.845 and 743.847 **and sections 3, 5, 8, 9, 10, 11, 12, 13 and 14 of this 2001 Act**.

(f) ORS 743.556, 743.701, 743.703, 743.704, 743.706, 743.707, 743.709, 743.710, 743.712, 743.713, 743.714, 743.717, 743.718, 743.719, 743.721, 743.722, 743.725 and 743.726. Multiple employer welfare arrangements to which ORS 743.730 to 743.773 apply are subject to the sections referred to in this paragraph only as provided in ORS 743.730 to 743.773.

(g) Provisions of ORS chapter 744 relating to the regulation of agents and insurance consultants, and ORS 744.700 to 744.740.

(h) ORS 746.005 to 746.140, 746.160, 746.180 and 746.220 to 746.370.

(i) ORS 731.592 and 731.594.

(2) For the purposes of this section:

(a) A trust carrying out a multiple employer welfare arrangement shall be considered an insurer.

(b) References to certificates of authority shall be considered references to certificates of multiple employer welfare arrangement.

(c) Contributions shall be considered premiums.

(3) The provision of health benefits under ORS 750.301 to 750.341 shall be considered to be the transaction of health insurance.

SECTION 18. Except as provided in section 19 of this 2001 Act, this 2001 Act does not become operative until July 1, 2002.

SECTION 19. The Director of the Department of Consumer and Business Services may take any action before the operative date of this 2001 Act that is necessary to enable the director to exercise, on and after the operative date of this 2001 Act, all the duties, functions and powers conferred on the director by this 2001 Act.

SECTION 20. The unit captions used in this 2001 Act are provided only for the convenience of the reader and do not become part of the statutory law of this state or express any legislative intent in the enactment of this 2001 Act.

Passed by House March 27, 2001

Repassed by House May 10, 2001

.....
Chief Clerk of House

.....
Speaker of House

Passed by Senate May 8, 2001

.....
President of Senate

Received by Governor:

.....M.,....., 2001

Approved:

.....M.,....., 2001

.....
Governor

Filed in Office of Secretary of State:

.....M.,....., 2001

.....
Secretary of State