

Senate Bill 887

Sponsored by COMMITTEE ON HEALTH CARE

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced**.

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

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

A BILL FOR AN ACT

1 Relating to health insurance coverage; creating new provisions; and amending ORS 743B.451.

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

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

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

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

6 (b) "New episode of care" means treatment for a new or recurrent condition for which
7 an enrollee in a health benefit plan has not been treated by a provider within the previous
8 90 days and is not currently undergoing any active treatment.

9 (c) "Provider" means a licensed provider that contracts with an insurer to provide:

10 (A) Chiropractic care;

11 (B) Acupuncture; or

12 (C) Massage therapy.

13 (d) "Visit" means, with respect to a provider of acupuncture, an interaction between a
14 provider and an enrollee for a period of no less than 30 minutes.

15 (2) An insurer offering a health benefit plan that reimburses the cost of chiropractic
16 care, acupuncture or massage therapy shall reimburse in each plan year, without prior au-
17 thorization, the cost of:

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

19 (b) Follow-up and management of the treatment for any condition that is within the
20 provider's scope of practice for the lesser of six visits or up to the maximum number of visits
21 prescribed by the policy or certificate of the health benefit plan.

22 (3) In addition to the visits for follow-up and management described in subsection (2) of
23 this section, the insurer must approve a minimum of the lesser of six additional visits or up
24 to the maximum number of visits prescribed by the policy or certificate of the health benefit
25 plan if the provider submits documentation, as prescribed by the Department of Consumer
26 and Business Services by rule, showing meaningful improvement in the enrollee's condition
27 as a result of the initial treatments.

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

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

1 **SECTION 3.** Section 4 of this 2019 Act is added to and made a part of ORS 243.105 to
2 **243.285.**

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

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

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

9 (A) Chiropractic care;

10 (B) Acupuncture; or

11 (C) Massage therapy.

12 (c) “Visit” means, with respect to a provider of acupuncture, an interaction between a
13 provider and an enrollee for a period of no less than 30 minutes.

14 (2) A benefit plan offered by the board that reimburses the cost of chiropractic care,
15 acupuncture or massage therapy shall reimburse in each plan year, without prior authori-
16 zation, the cost of:

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

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

21 (3) In addition to the visits for follow-up and management described in subsection (2) of
22 this section, the board or a third party administrator on behalf of the board must approve
23 a minimum of the lesser of six additional visits or up to the maximum number of visits al-
24 lowed under the benefit plan if the provider submits documentation, as prescribed by the
25 Department of Consumer and Business Services by rule, showing meaningful improvement
26 in the enrollee’s condition as a result of the initial treatments.

27 **SECTION 5.** Section 6 of this 2019 Act is added to and made a part of ORS 243.860 to
28 **243.886.**

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

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

33 (b) “Provider” means a licensed provider that contracts with the Oregon Educators
34 Benefit Board to provide:

35 (A) Chiropractic care;

36 (B) Acupuncture; or

37 (C) Massage therapy.

38 (c) “Visit” means, with respect to a provider of acupuncture, an interaction between a
39 provider and an enrollee for a period of no less than 30 minutes.

40 (2) A benefit plan offered by the board that reimburses the cost of chiropractic care,
41 acupuncture or massage therapy shall reimburse in each plan year, without prior authori-
42 zation, the cost of:

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

44 (b) Follow-up and management of the treatment for any condition that is within the
45 provider’s scope of practice for the lesser of six visits or up to the maximum number of visits

1 **allowed under the benefit plan.**

2 **(3) In addition to the visits for follow-up and management described in subsection (2) of**
 3 **this section, the board or a third party administrator on behalf of the board must approve**
 4 **a minimum of the lesser of six additional visits or up to the maximum number of visits al-**
 5 **lowed under the benefit plan if the provider submits documentation, as prescribed by the**
 6 **Department of Consumer and Business Services by rule, showing meaningful improvement**
 7 **in the enrollee's condition as a result of the initial treatments.**

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

9 743B.451. (1) As used in this section[,]:

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

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

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

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

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

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

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

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

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

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

29 **(B) Specifies in the written request why the health insurer believes the provider owes the re-**
 30 **fund.**

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

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

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

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

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

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

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

44 **(4) If a health care provider fails to contest a refund request in writing to the health insurer**
 45 **within 30 days after receiving the request, the request is deemed accepted and the provider must**

1 pay the refund within 30 days after the request is deemed accepted. If the provider has not paid the
2 refund within 30 days after the request is deemed accepted, the health insurer may recover the
3 amount through an offset to a future claim.

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

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

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

10 (6) If a contract between a health insurer and a health care provider conflicts with this section,
11 the provisions of this section prevail. However, nothing in this section prohibits a health care pro-
12 vider from choosing at any time to refund to a health insurer any payment previously made to sat-
13 isfy a claim.

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

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

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

21 **(2) The amendments to ORS 743B.451 by section 7 of this 2019 Act apply to claims which**
22 **are approved by a health insurer in writing, online or by telephone on or after the effective**
23 **date of this 2019 Act.**