

1 **836-052-0508**

2 **Definitions**

3 For the purpose of OAR 836-052-0500 to [836-052-0786] **836-052-0790**[, ]:

4 **(1)** The **following** terms [*"long term care insurance," "qualified long term care insurance," "group long*  
5 *term care insurance," "applicant," "policy" and "certificate"*] have the meanings given those terms in  
6 ORS 743.652:

7 **(a) "Applicant;"**

8 **(b) "Benefit trigger;"**

9 **(c) "Certificate;"**

10 **(d) "Group long term care insurance;"**

11 **(e) "Long term care insurance;"**

12 **(f) "Policy;" and**

13 **(g) "Qualified long term care insurance."**

14 **(2)** [*In addition,*] The following definitions apply:

15 [(1)] **(a) "Independent review organization"** means an organization qualified under OAR 836-052-  
16 **0768(5)** that conducts independent reviews of long-term care benefit trigger decisions.

17 **(b) "Licensed health care professional"** means an individual qualified by education and experience in  
18 **an appropriate field, to determine, by record review, an insured's actual functional or cognitive**  
19 **impairment.**

20 **(c) "Qualified actuary"** means a member in good standing of the American Academy of Actuaries.

21 [(2)] **(d) "Similar policy forms"** means all of the long term care insurance policies and certificates issued  
22 by an insurer in the same long term care benefit classification as the policy form being considered.

23 Certificates of groups that meet the definition of ORS 743.652(3)(a) are not considered similar to  
24 certificates or policies otherwise issued as long term care insurance, but are similar to other comparable  
25 certificates with the same long term care benefit classifications.

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27 Stat. Auth.: ORS 731.244, 742.023, 743.013, 743.655, 743.685 & 746.240, OL 2007 Ch. 9, 9a

28 Stats. Implemented: ORS 742.003, 742.005, 743.650, 743.655 & 743.656

29 Hist.: ID 10-2007, f. 12-3-07, cert. ef. 1-1-08

30

31 **836-052-0768**

32 **Appealing An Insurer's Determination That The Benefit Trigger Is Not Met**

33

34 **(1) For purposes of this rule, "authorized representative" means a person who is authorized to act as**  
35 **the covered person's personal representative within the meaning of 45 CFR 164.502(g) promulgated**  
36 **by the Secretary of the Department of Health and Human Services under the administrative**  
37 **simplification provisions of the Health Insurance Portability and Accountability Act. "Authorized**  
38 **representative" includes the following:**

39 **(a) A person to whom a covered person has given express written consent to represent the covered**  
40 **person in an external review;**

41 **(b) A person authorized by law to provide substituted consent for a covered person; or**

1 (c) A family member of the covered person or the covered person's treating health care professional  
2 only when the covered person is unable to provide consent.

3 (2) If an insurer determines that the benefit trigger of a long-term care insurance policy has not been  
4 met, the insurer shall provide a clear, written notice to the insured and the insured's authorized  
5 representative, if applicable, of all of the following:

6 (a) The reason that the insurer determined that the insured's benefit trigger has not been met;  
7 (b) The insured's right to internal appeal in accordance with section (3) of this rule, and the right to  
8 submit new or additional information relating to the benefit trigger denial with the appeal request;  
9 and

10 (c) The insured's right, after exhaustion of the insurer's internal appeal process, to have the benefit  
11 trigger determination reviewed under the independent review process in accordance with section (4)  
12 of this rule.

13 (3) The insured or the insured's authorized representative may appeal the insurer's adverse benefit  
14 trigger determination by sending a written request to the insurer, along with any additional  
15 supporting information, within 120 calendar days after the insured and the insured's authorized  
16 representative, if applicable, receives the insurer's benefit determination notice. The internal appeal  
17 shall be considered by an individual or group of individuals designated by the insurer, but the  
18 individual or individuals making the internal appeal decision may not be the same individual or group  
19 of individuals who made the initial benefit determination. The internal appeal shall be completed and  
20 written notice of the internal appeal decision shall be sent to the insured and the insured's authorized  
21 representative, if applicable, within 30 calendar days after the insurer receives all necessary  
22 information upon which a final determination can be made.

23 (a) If the insurer's original determination is upheld upon internal appeal, the notice of the internal  
24 appeal decision shall describe any additional internal appeal rights offered by the insurer. Nothing in  
25 this rule shall require the insurer to offer any internal appeal rights other than those described in this  
26 subsection.

27 (b) If the insurer's original determination is upheld after the internal appeal process has been  
28 exhausted, and new or additional information has not been provided to the insurer, the insurer shall  
29 provide a written description of the insured's right to request an independent review of the benefit  
30 determination as described in section (4) of this rule to the insured and the insured's authorized  
31 representative, if applicable.

32 (c) As part of the written description of the insured's right to request an independent review, an  
33 insurer shall include the following, or substantially equivalent, language: "We have determined that  
34 the benefit eligibility criteria ("benefit trigger") of your [policy] [certificate] has not been met. You  
35 may have the right to an independent review of our decision conducted by long-term care  
36 professionals who are not associated with us. Please send a written request for independent review  
37 to us at [address]. You must inform us, in writing, of your election to have this decision reviewed  
38 within 120 days after you receive this letter. Listed below are the names and contact information of  
39 the independent review organizations approved or certified by the Department of Consumer and  
40 Business Services to conduct long-term care insurance benefit eligibility reviews. If you wish to  
41 request an independent review, please choose one of the listed organizations and include its name  
42 with your request for independent review. If you elect independent review, but do not choose an

1 independent review organization with your request, we will choose one of the independent review  
2 organizations for you and refer the request for independent review to it.”  
3 (d) If the insurer does not believe the benefit trigger decision is eligible for independent review, the  
4 insurer shall inform the insured and the insured’s authorized representative, if applicable, and the  
5 director of the Department of Consumer and Business Services in writing and include in the notice the  
6 reasons for its determination of independent review ineligibility.  
7 (e) The appeal process described in section (3) of this rule is not deemed to be a ‘new service or  
8 provider’ as referenced in OAR 836-052-0738, and therefore does not trigger the notice requirements  
9 of that rule.  
10 (4) (a) The insured or the insured’s authorized representative may request an independent review of  
11 the insurer’s benefit trigger determination after the internal appeal process outlined in section (3) of  
12 this rule is exhausted. A written request for independent review may be made by the insured or the  
13 insured’s authorized representative to the insurer within 120 calendar days after the insurer’s written  
14 notice of the final internal appeal decision is received by the insured and the insured’s authorized  
15 representative, if applicable.  
16 (b) The cost of the independent review shall be borne by the insurer.  
17 (c) An independent review process shall comply with all of these procedures:  
18 (A) Within five business days after receiving a written request for independent review, the insurer  
19 shall refer the request to the independent review organization that the insured or the insured’s  
20 authorized representative has chosen from the list of certified or approved organizations the insurer  
21 has provided to the insured. If the insured or the insured’s authorized representative does not choose  
22 an approved independent review organization to perform the review, the insurer shall choose an  
23 independent review organization approved or certified by the state. The insurer shall vary its selection  
24 of authorized independent review organizations on a rotating basis.  
25 (B) The insurer shall refer the request for independent review of a benefit trigger determination to an  
26 independent review organization, subject to the following:  
27 (i) The independent review organization shall be on a list of certified or approved independent review  
28 organizations that satisfy the requirements of a qualified long-term care insurance independent  
29 review organization contained in this section;  
30 (ii) The independent review organization may not have any conflicts of interest with the insured, the  
31 insured’s authorized representative, if applicable, or the insurer; and  
32 (iii) The independent review shall be limited to the information or documentation provided to and  
33 considered by the insurer in making its determination, including any information or documentation  
34 considered as part of the internal appeal process.  
35 (C) If the insured or the insured’s authorized representative has new or additional information not  
36 previously provided to the insurer, whether submitted to the insurer or the independent review  
37 organization, the information shall first be considered in the internal review process, as set forth in  
38 section (3) of this rule.  
39 (i) While the insurer is reviewing the new or additional information, the independent review  
40 organization shall suspend its review and the time period for review is suspended until the insurer  
41 completes its review.

1 (ii) The insurer must complete its review of the information and provide written notice of the results  
2 of the review to the insured and the insured's authorized representative, if applicable, and the  
3 independent review organization within five business days of the insurer's receipt of such new or  
4 additional information.

5 (iii) If the insurer maintains its denial after the review of the new or additional information not  
6 previously provided to the insurer, the independent review organization shall continue its review, and  
7 render its decision within the time period specified in paragraph (I) of this subsection. If the insurer  
8 overturns its decision following its review, the independent review request shall be considered  
9 withdrawn.

10 (D) The insurer shall acknowledge in writing to the insured and the insured's authorized  
11 representative, if applicable, and the director that the request for independent review has been  
12 received, accepted and forwarded to an independent review organization for review. The notice must  
13 include the name and address of the independent review organization.

14 (E) Within five business days after receipt of the request for independent review, the independent  
15 review organization assigned under this subsection shall notify the insured and the insured's  
16 authorized representative, if applicable, the insurer and the director that it has accepted the  
17 independent review request and identify the type of licensed health care professional assigned to the  
18 review. The assigned independent review organization shall include in the notice a statement that the  
19 insured or the insured's authorized representative may submit in writing to the independent review  
20 organization within seven days following the date of receipt of the notice additional information and  
21 supporting documentation that the independent review organization should consider when  
22 conducting its review.

23 (F) The independent review organization shall review all of the information and documents received  
24 pursuant to paragraph (E) of this subsection that has been provided to the independent review  
25 organization. The independent review organization shall provide copies of any documentation or  
26 information provided by the insured or the insured's authorized representative to the insurer for its  
27 review, if it is not part of the information or documentation submitted by the insurer to the  
28 independent review organization. The insurer shall review the information and provide its analysis of  
29 the new information in accordance with subparagraph (H) of this paragraph.

30 (G) The insured or the insured's authorized representative may submit, at any time, new or additional  
31 information not previously provided to the insurer but pertinent to the benefit trigger denial. The  
32 insurer shall consider such information and affirm or overturn its benefit trigger determination. If the  
33 insurer affirms its benefit trigger determination, the insurer shall promptly provide such new or  
34 additional information to the independent review organization for its review, along with the insurer's  
35 analysis of such information.

36 (H) If the insurer overturns its benefit trigger determination:

37 (i) The insurer shall provide notice to the independent review organization and the insured and the  
38 insured's authorized representative, if applicable, and the director of its decision; and

39 (ii) The independent review process shall immediately cease.

40 (I) The independent review organization shall provide the insured and the insured's authorized  
41 representative, if applicable, the insurer and the director a written notice of its decision, within 30  
42 calendar days after the independent review organization receives the referral referenced in

1 subsection (c)(B) of this section. If the independent review organization overturns the insurer's  
2 decision, it shall:

3 (i) Establish the precise date within the specific period of time under review that the benefit trigger  
4 was deemed to have been met;

5 (ii) Specify the specific period of time under review for which the insurer declined eligibility, but  
6 during which the independent review organization deemed the benefit trigger to have been met; and  
7 (iii) For tax-qualified long-term care insurance contracts, provide a certification (made only by a  
8 licensed health care practitioner as defined in section 7702B(c)(4) of the Internal Revenue Code) that  
9 the insured is a chronically ill individual.

10 (J) The decision of the independent review organization with respect to whether the insured met the  
11 benefit trigger will be final and binding on the insurer.

12 (K) The independent review organization's determination shall be used solely to establish liability for  
13 benefit trigger decisions, and is intended to be admissible in any proceeding only to the extent it  
14 establishes the eligibility of benefits payable.

15 (L) Nothing in this section shall restrict the insured's right to submit a new request for benefit trigger  
16 determination after the independent review decision, should the independent review organization  
17 uphold the insurer's decision.

18 (M) The independent review organization must satisfy the criteria set forth in Exhibit 1, Guidelines for  
19 Long-Term Care Independent Review Entities, in order to be certified or approved by the department  
20 to review long-term care insurance benefit trigger decisions.

21 (N) The director shall maintain and periodically update a list of approved independent review  
22 organizations.

23 (5) Certification of Long-Term Care Insurance Independent Review Organizations. The director may  
24 certify or approve a qualified long-term care insurance independent review organization, if the  
25 independent review organization demonstrates to the satisfaction of the director that it is unbiased  
26 and meets the following qualifications:

27 (a) Have on staff, or contract with, a qualified and licensed health care professional in an appropriate  
28 field for determining an insured's functional or cognitive impairment (e.g. physical therapy,  
29 occupational therapy, neurology, physical medicine and rehabilitation) to conduct the review.

30 (b) Neither the organization nor any of its licensed health care professionals may, in any manner, be  
31 related to or affiliated with an entity that previously provided medical care to the insured.

32 (c) Utilize a licensed health care professional who is not an employee of the insurer or related in any  
33 manner to the insured.

34 (d) Neither it nor its licensed health care professional who conducts the reviews may receive  
35 compensation of any type that is dependent on the outcome of the review.

36 (e) Be state approved or certified to conduct such reviews if the state requires such approvals or  
37 certifications.

38 (f) Provide a description of the fees to be charged by it for independent reviews of a long-term care  
39 insurance benefit trigger decision. Such fees shall be reasonable and customary for the type of long-  
40 term care insurance benefit trigger decision under review.

41 (g) Provide the name of the medical director or health care professional responsible for the  
42 supervision and oversight of the independent review procedure.

1 (h) Have on staff or contract with a licensed health care practitioner, as defined by section 7702B(c)(4)  
2 of the Internal Revenue Code of 1986, as amended, who is qualified to certify that an individual is  
3 chronically ill for purposes of a qualified long-term care insurance contract.

4 (6) Each certified independent review organization shall comply with the following:

5 (a) Maintain written documentation establishing the date it receives a request for independent  
6 review, the date each review is conducted, the resolution, the date such resolution was  
7 communicated to the insurer and the insured, the name and professional status of the reviewer  
8 conducting such review in an easily accessible and retrievable format for the year in which it received  
9 the information, plus two calendar years.

10 (b) Be able to document measures taken to appropriately safeguard the confidentiality of such  
11 records and prevent unauthorized use and disclosures in accordance with applicable federal and state  
12 law.

13 (c) Report annually to the director, by June 1, in the aggregate and for each long-term care insurer all  
14 of the following:

15 (A) The total number of requests received for independent review of long term care benefit trigger  
16 decisions;

17 (B) The total number of reviews conducted and the resolution of such reviews (i.e., the number of  
18 reviews which upheld or overturned the long-term care insurer's determination that the benefit  
19 trigger was not met);

20 (C) The number of reviews withdrawn prior to review;

21 (D) The percentage of reviews conducted within the prescribed timeframe set forth in subsection  
22 (4)(c)(I) of this rule; and

23 (E) Such other information the director may require.

24 (d) Report immediately to the director any change in its status which would cause it to cease meeting  
25 any of the qualifications required of an independent review organization performing independent  
26 reviews of long term care benefit trigger decisions.

27 (7) Nothing contained in this rule shall limit the ability of an insurer to assert any rights an insurer may  
28 have under the policy related to:

29 (a) An insured's misrepresentation;

30 (b) Changes in the insured's benefit eligibility; and

31 (c) Terms, conditions, and exclusions of the policy, other than failure to meet the benefit trigger.

32 (8) The requirements of this rule apply to a benefit trigger request made on or after July 1, 2012 under  
33 a long-term care insurance policy issued or renewed after July 1, 2012.

34 (9) The provisions of this rule supersede any other external review requirements found in ORS  
35 743.857, 743.858, 743.859, 743.861, 743.862, 743.863 and 743.864.

36  
37 Stat. Auth.: ORS 731.244, 743.655 and Section 5, chapter 69, Oregon Laws 2011 (Enrolled Senate Bill 88)

38 Stats. Implemented: ORS 743.655 and Section 5, chapter 69, Oregon Laws 2011 (Enrolled Senate Bill 88)

39 Hist.:

40  
41 836-052-0770 (NEW)

42 Prompt Payment of Clean Claims

1  
2 **(1) For purposes of this rule:**

3 **(a) "Claim" means a request for payment of benefits under an in-force policy, regardless of whether**  
4 **the benefit claimed is covered under the policy or any terms or conditions of the policy have been**  
5 **met.**

6 **(b) "Clean claim" means a claim that has no defect or impropriety, including any lack of required**  
7 **substantiating documentation, such as satisfactory evidence of expenses incurred, or particular**  
8 **circumstance requiring special treatment that prevents timely payment from being made on the**  
9 **claim.**

10 **(2) Within 30 business days after receipt of a claim for benefits under a long term care insurance**  
11 **policy or certificate, an insurer shall pay the claim if it is a clean claim, or send a written notice**  
12 **acknowledging the date of receipt of the claim and one of the following:**

13 **(a) The insurer is declining to pay all or part of the claim and the specific reason for denial; or**

14 **(b) That additional information is necessary to determine if all or any part of the claim is payable and**  
15 **the specific additional information that is necessary.**

16 **(3) Within 30 business days after receipt of all the requested additional information, an insurer shall**  
17 **pay a claim for benefits under a long-term care insurance policy or certificate if it is a clean claim, or**  
18 **send a written notice that the insurer is declining to pay all or part of the claim, and the specific**  
19 **reason for denial.**

20 **(4) If an insurer fails to comply with section (2) or (3) of this rule, such insurer shall pay interest at the**  
21 **rate of 1% per month on the amount of the claim that should have been paid but that remains unpaid**  
22 **45 business days after the receipt of the claim with respect to section (2) of this rule or all requested**  
23 **additional information with respect to section (3) of this rule. The interest payable under this section**  
24 **shall be included in any late reimbursement without requiring the person who filed the original claim**  
25 **to make any additional claim for the interest.**

26 **(5) The provisions of this rule shall not apply where the insurer has a reasonable basis supported by**  
27 **specific information that a claim was fraudulently submitted.**

28 **(6) Any violation of this rule by an insurer if committed flagrantly and in conscious disregard of the**  
29 **provisions of this rule or with such frequency as to constitute a general business practice shall be**  
30 **considered a violation of the ORS 746.230.**

31 **(7) The provisions of this rule supersede any other claim payment requirement found in ORS 746.230.**

32  
33 Stat. Auth.: ORS 731.244 and 743.655 and Section 2, chapter 69, Oregon Laws 2011 (Enrolled Senate Bill  
34 88)

35 Stats. Implemented: ORS 743.655 and Section 2, chapter 69, Oregon Laws 2011 (Enrolled Senate Bill 88)

36 Hist.:

37