

DIVISION 53
HEALTH BENEFIT PLANS
Individual Health Benefit Plans

836-053-0410 (AMENDED)

Purpose; Statutory Authority; Enforcement

(1) OAR 836-053-0410 to 836-053-0465 are adopted under the authority of ORS 743.769 and section 4a, chapter 500, Oregon Laws 2011 (Enrolled Senate Bill 89) for the purpose of implementing ORS 743.766 to 743.769, and section 4a, chapter 500, Oregon Laws 2011 (Enrolled Senate Bill 89) relating to individual health benefit plans.

(2) Violation of any provision of OAR 836-053-0430 to 836-053-0465 is an unfair trade practice under ORS 746.240.

Stat. Auth.: ORS 743.769 and section 4a, chapter 500, Oregon Laws 2011 (Enrolled Senate Bill 89)

Stats. Implemented: ORS 743.766 - ORS 743.769 and section 4a, chapter 500, Oregon Laws 2011 (Enrolled Senate Bill 89)

Hist.: ID 12-1996, f. & cert. ef. 9-23-96; ID 5-1998, f. & cert. ef. 3-9-98

836-053-0415 (NEW)

Cancellation of an Individual Health Benefit Plan Coverage

The notice requirements of section 4a, chapter 500, Oregon Laws 2011 (Enrolled Senate Bill 89), are triggered at the time an insurer takes administrative action to terminate coverage.

Stat. Auth.: ORS 743.769 and section 4a, chapter 500, Oregon Laws 2011 (Enrolled Senate Bill 89)

Stats. Implemented: ORS 743.766 - ORS 743.769 and section 4a, chapter 500, Oregon Laws 2011 (Enrolled Senate Bill 89)

Hist.:

**Rescission of Health Insurance or Individual, Group or Portability Health Benefit Plan
(New Subheading Following 836-053-0800)**

836-053-0825 (NEW)

Rescission of a Group Health Benefit Plan

(1) For purposes of ORS 743.737 and 743.754, “representative” means a person who, with specific authority from the small employer or plan sponsor to do so, binds the small employer or plan sponsor to a contract for health benefit plan coverage.

(2) The notice required by ORS 743.737 and 743.754 and section 4(3), chapter 500, Oregon Laws 2011 (Enrolled Senate Bill 89) to each plan enrollee affected by the rescission must be in writing and include all of the following:

1 **(a) Clear identification of the alleged fraudulent act, practice or omission or the intentional**
2 **misrepresentation of material fact underlying the rescission.**

3 **(b) An explanation of why the act, practice or omission was fraudulent or was an**
4 **intentional misrepresentation of a material fact.**

5 **(c) A statement explaining any rights to grieve or request a review of the decision to rescind**
6 **coverage.**

7 **(d) A description of the health carrier's applicable grievance procedures, including any**
8 **time limits applicable to those procedures.**

9 **(e) A statement explaining that complaints relating to the subject matter of the notice**
10 **required under ORS 743.737 and 743.754 and section 4(3), chapter 500, Oregon Laws 2011**
11 **(Enrolled Senate Bill 89) may be made with the Insurance Division of the Department of**
12 **Consumer and Business Services by writing to the Insurance Division at PO Box 14480,**
13 **Salem, OR 97309-0405; by calling (503) 947-7984 or (888) 877-4894; or by email at**
14 **<http://www.cbs.state.or.us/ins/consumer/consumer.html> or cp.ins@state.or.us . The**
15 **statement shall also explain that complaints to the Insurance Division do not constitute**
16 **grievances under the health benefit plan and may not preserve a member's rights under**
17 **the plan.**

18 **(f) The toll-free customer service number of the insurer.**

19 **(g) The effective date of the rescission and the date back to which the coverage will be**
20 **rescinded.**

21 **(3) Subject to section 3, chapter 75, Oregon Laws 2010 (Enrolled House Bill 3666), a health**
22 **carrier may provide the required notice for small employer group health insurance or**
23 **individual health insurance either by first class mail or electronically.**

24 **(4) (a) An insurer shall provide to the Department of Consumer and Business Services the**
25 **notice required by ORS 743.737(8)(c) and (9)(c), 743.754(8)(c) and (9)(c) and section 4(4),**
26 **chapter 500, Oregon Laws 2011 (Enrolled Senate Bill 89) no later than February 15 of each**
27 **calendar year. The insurer shall submit the notice electronically in accordance with**
28 **instructions provided by the department. The notice shall include information related to**
29 **rescissions for the prior calendar year, including but not limited to the total number of:**

30 **(A) Rescission reviews started;**

31 **(B) Rescissions completed;**

32 **(C) Total rescissions of an entire insurance policy;**

33 **(D) Partial rescissions;**

34 **(E) Individual policies in force on December 31 of the report year;**

35 **(F) Individual health benefit plans that had either a full or partial rescission;**

36 **(G) Group health benefit plans in force on December 31 of the report year; and**

37 **(H) Group health benefit plans that had either a full or partial rescission.**

38 **(b) The notice required under this section may be combined with the notice required under**
39 **OAR 836-053-0830.**

40
41 Stat. Auth.: ORS 743.018, 743.019, 743.020, **& section 4, chapter 500, Oregon Laws 2011**
42 **(Enrolled Senate Bill 89)**

43 Stats. Implemented: ORS 742.003, 742.005, 742.007, 743.018, 743.019, 743.020, 743.730,
44 743.737, 743.754, & 743.767 **& section 4, chapter 500, Oregon Laws 2011 (Enrolled Senate**
45 **Bill 89)**

46 Hist.:

1
2 **836-053-0830 (NEW)**

3 **Rescission of an Individual's Group, Individual or Portability Health Benefit Plan, or**
4 **Group or Individual Health Insurance Coverage.**

5
6 **(1) Subject to the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended,**
7 **P.L. 99-272, April 7, 1986, and ORS 743.601 and 743.610, for purposes of rescission of a**
8 **group health insurance policy under ORS 743.737 and 743.754 and section 4(2), chapter**
9 **500, Oregon Laws 2011 (Enrolled Senate Bill 89), "rescission" does not include retroactive**
10 **cancellation or discontinuance of coverage of an enrollee if:**

11 **(a) The enrollee is no longer eligible for such coverage;**

12 **(b) The enrollee has not paid required premiums or contributed to coverage or any**
13 **premiums paid have been refunded; and**

14 **(c) The insurer is not notified of the enrollee's change in eligibility when the change occurs.**

15 **(2) The notice required by section 4(2), chapter 500, Oregon Laws 2011 (Enrolled Senate**
16 **Bill 89) to the individual whose coverage is rescinded must be in writing and include all of**
17 **the following:**

18 **(a) Clear identification of the alleged fraudulent act, practice or omission or the intentional**
19 **misrepresentation of material fact underlying the rescission.**

20 **(b) An explanation as to why the act, practice or omission was fraudulent or was an**
21 **intentional misrepresentation of a material fact.**

22 **(c) A statement informing the individual of any right the individual has to file a grievance**
23 **or to request a review of the decision to rescind coverage.**

24 **(d) A description of the health carrier's grievance procedures, including any time limits**
25 **applicable to those procedures if such procedures are available to the individual.**

26 **(e) A statement explaining that complaints relating to the subject matter of the notice**
27 **required under this section may be made with the Oregon Insurance Division at PO Box**
28 **14480, Salem, OR 97309-0405; (503) 947-7984 or (888) 877-4894;**

29 **<http://www.cbs.state.or.us/ins/consumer/consumer.html>; or cp.ins@state.or.us and that**
30 **such complaints do not constitute grievances.**

31 **(f) The toll-free customer service number of the insurer.**

32 **(g) The effective date of the rescission and the date back to which the coverage will be**
33 **rescinded.**

34 **(3) Subject to chapter 75, Oregon Laws 2010 (Enrolled House Bill 3666), a health carrier**
35 **may provide the notice required under section 4(2), chapter 500, Oregon Laws 2011**
36 **(Enrolled Senate Bill 89) for small employer group health insurance or individual health**
37 **insurance either by first class mail or electronically.**

38 **(4) (a) An insurer shall provide to the Director of the Department of Consumer and**
39 **Business Services the notice required by section 4(4), chapter 500, Oregon Laws 2011**
40 **(Enrolled Senate Bill 89) no later than February 15 of each calendar year. The insurer**
41 **shall submit the notice electronically in accordance with instructions provided by the**
42 **department. The notice shall include information related to rescissions for the prior**
43 **calendar year, including but not limited to the total number of:**

44 **(A) Rescission reviews started;**

45 **(B) Rescissions completed;**

46 **(C) Total rescissions of an entire insurance policy;**

- 1 **(D) Partial rescissions;**
2 **(E) Individual policies in force on December 31 of the report year;**
3 **(F) Individual health benefit plans that had either a full or partial rescission;**
4 **(G) Group health benefit plans in force on December 31 of the report year; and**
5 **(H) Group health benefit plans that had either a full or partial rescission.**
6 **(b) The notice required under this section may be combined with the notice required under**
7 **OAR 836-053-0825.**

8
9 Stat. Auth.: ORS 731.244 **& section 4, chapter 500, Oregon Laws 2011 (Enrolled Senate Bill**
10 **89)**

11 Stats. Implemented: ORS 743.731 **& section 4, chapter 500, Oregon Laws 2011 (Enrolled**
12 **Senate Bill 89)**

13 Hist.:

14
15 State Continuation of Health Insurance

16
17 836-053-0851 (AMENDED)

18 Purpose; Authority; Applicability; and Enforcement

19
20 *[(1) OAR 836-053-0851 to 836-053-0866 are permanent rules that repeal and replace*
21 *permanent rules OAR 836-053-0850 to 836-053-0865 and temporary amendments to those rules*
22 *OAR 836-053-0850T to 836-053-0885T and are adopted under the authority of ORS 731.244*
23 *and chapter 73, Oregon Laws 2009 (Enrolled House Bill 2433) for the purpose of implementing*
24 *continuation of benefits provisions in accordance with chapter 73, Oregon Laws 2009 (Enrolled*
25 *House Bill 2433) and for the purpose of maximizing the benefit certificate holders in Oregon*
26 *may receive under the American Recovery and Reinvestment Act of 2009 (P.L. 111-5).]*

27 *[(2)] OAR 836-053-0851 to [836-053-0866] **836-053-0862** apply to insurers issuing continuation*
28 *coverage as required under ORS 743.610 **and are adopted under the authority of ORS***
29 ***731.244, 743.601 and 743.610 and section 2, chapter 73, Oregon Laws 2009.***

30
31 Stat. Auth.: ORS 731.244, 743.610 & 2009 OL Ch. 73 (HB 2433)

32 Stats. Implemented: ORS 743.610 & 2009 OL Ch. 73 (HB 2433)

33 Hist.: ID 12-2010, f. & cert. ef. 6-11-10

34
35 **836-053-0857 (NEW)**

36 **Definitions**

37
38 **(1) As used in ORS 743.601, “enrollee” has the same meaning as “covered person” as**
39 **defined in ORS 743.610.**

40 **(2) As used in ORS 743.610:**

41 **(a) “Claim” means a request for payment of medical treatment, services, drugs, equipment,**
42 **or other medical benefit under a health benefit plan.**

43 **(b) “Notice” means the notice provided by an insurer to a covered person or qualified**
44 **beneficiary about continuing group coverage after a qualifying event.**

45 **(c) “Qualified beneficiary” does not include:**

46 **(A) An individual eligible for Federal Medicare coverage.**

1 **(B) An individual eligible for any other group health plan. This limitation does not apply to**
2 **coverage consisting only of:**

3 **(i) Dental, vision, counseling, or referral services;**

4 **(ii) Coverage under a health flexible spending arrangement as defined in section 106(c)(2)**
5 **of the Internal Revenue Code of 1986; or**

6 **(iii) Treatment that is furnished in an on-site medical facility maintained by an employer.**

7 **(d) “Similar” means a plan that provides benefits that are the same or nearly the same as**
8 **the coverage provided under the group health benefit plan that is being terminated.**

9 **(3) As used in ORS 743.610(7)(a), “coverage” means the benefits provided under a health**
10 **benefit plan continued by a covered person or qualified beneficiary.**

11 **(4) As used in ORS 743.601 and 743.610 “dissolution” includes a separation upon a**
12 **judgment of separation granted pursuant to ORS 107.025.**

13
14 Stat. Auth.: ORS 731.244, **743.601, & 743.610** [& 2009 OL Ch. 73 (HB 2433)]

15 Stats. Implemented: ORS **743.601 & 743.610** [& 2009 OL Ch. 73 (HB 2433)]

16 Hist.:

17
18 **836-053-0862 (NEW)**

19 **Notifications**

20
21 **(1) For purposes of the notice required by ORS 743.610(10):**

22 **(a) An insurer may provide a single notice under ORS 743.610(10) to a covered person and**
23 **a qualified beneficiary when:**

24 **(A) The notice is addressed to the covered person or qualified beneficiary at the last known**
25 **address of the covered person or qualified beneficiary;**

26 **(B) The covered person and qualified beneficiary are eligible for state continuation**
27 **coverage by virtue of the same qualifying event; and**

28 **(C) The covered person and qualified beneficiary have the same last known mailing**
29 **address.**

30 **(b) An insurer that does not require a covered person or qualified beneficiary to complete a**
31 **form to request continuation of coverage need not include a form in the notice. However,**
32 **the insurer must provide sufficient instructions to inform the covered person or qualified**
33 **beneficiary how to apply for continuation of coverage.**

34 **(c) An insurer is not required to include premium rates in the notice. However, an insurer**
35 **that does not provide premium rates for continuation of coverage in the notice must**
36 **instruct the covered person or qualified beneficiary how and from whom the premium**
37 **rates can be obtained.**

38 **(d) The requirement to provide written notice under ORS 743.610(1) may be triggered**
39 **either by the notification of a qualifying event received from the covered person or**
40 **qualified beneficiary under ORS 743.610(5) or notice of the qualifying event submitted to**
41 **the insurer by the group policy holder.**

42 **(e) The enrollment information required to be in the notice under ORS 743.610(10) may**
43 **instruct the covered person or qualified beneficiary to contact the employer or group for**
44 **information about additional coverage for which the covered person or qualified**
45 **beneficiary may be eligible.**

1 **(f) The explanation of appeal rights required to be included in the notice under ORS**
2 **743.610(1) may be provided by a statement that continuation coverage constitutes**
3 **continued coverage under the group policy and that the covered person or qualified**
4 **beneficiary has the same rights to appeal or grieve a decision by the insurer on a medical**
5 **claim that exists under the group policy unless the group policy has been replaced with**
6 **coverage that provides different appeal or grievance rights.**
7 **(2) Notice provided under ORS 743.610 must include the following information: “Oregon**
8 **Insurance Division - (503) 947-7984 or (888) 877-4894.”**
9

10 Stat. Auth.: ORS 731.244, **743.601 &** 743.610[& 2009 OL Ch. 73 (HB 2433)]

11 Stats. Implemented: ORS **743.601 &** 743.610[& 2009 OL Ch. 73 (HB 2433)]

12 Hist.:

13
14 [836-053-0856 (REPEALED)]

15 [Definitions]

16
17 [As used in OAR 836-053-0851 to 836-053-0866]

18 [(1) “American Recovery and Reinvestment Act of 2009” means the Public Law 111-5 as
19 amended by Public Law 111-118, the Fiscal Year 2010 Department of Defense Appropriations
20 Act (HR 3326), and as further amended by Public Law 111-144, the Temporary Extension Act of
21 2010 (HR 4691) and Public Law 111-157, the Continuing Extension Act of 2010 (HR 4851).

22 [(2) “Certificate holder” means any covered employee or qualified beneficiary who:]

23 [(a) Is eligible for continuation coverage because the employee is no longer eligible for coverage
24 under group health plan due to reduction of hours of employment or termination of employment;

25 [(b) Elects continuation coverage;]

26 [(c) Is subject to a qualifying event; and]

27 [(d) Is considered an assistance eligible individual under the American Recovery and
28 Reinvestment Act of 2009 (P.L. 111-5)].

29 [(3) “Involuntary termination” means a qualifying event in which the employer determines,
30 based on a reasonable interpretation of the description of an assistance eligible individual under
31 the American Recovery and Reinvestment Act of 2009 and administrative guidance provided
32 under the American Recovery and Reinvestment Act of 2009, that the qualifying event with
33 respect to state continuation coverage for an individual was involuntary termination of a
34 covered employee’s employment, and the employer maintains supporting documentation of the
35 determination, including an attestation by the employer of involuntary termination with respect
36 to the covered employee.]

37 [(4) “Covered employee” means a certificate holder who has been insured continuously under a
38 policy or similar predecessor policy during the three-month period ending on the date of the
39 termination of employment or membership.]

40 [(5)(a) “Qualified beneficiary” means a covered employee under a group health plan or any
41 other individual who, on the day before the qualifying event for that employee, is a beneficiary
42 under that plan as the spouse of the covered employee or as the dependent child of the employee,
43 including a child born or placed for adoption after the qualifying event or during the period the
44 covered employee is eligible for continuation coverage.]

45 [(b) An individual is not a qualified beneficiary if]:

46 [(A) The individual is eligible for Federal Medicare coverage].

1 *[(B) The individual is eligible for any other group health plan. This limitation does not apply to*
2 *coverage consisting only of:]*
3 *[(i) Dental, vision, counseling, or referral services;]*
4 *[(ii) Coverage under a health flexible spending arrangement as defined in section 106(c)(2) of*
5 *the Internal Revenue Code of 1986; or]*
6 *[(iii) Treatment that is furnished in an on-site medical facility maintained by an employer.]*
7 *[(C) An individual is not a qualified beneficiary only for purposes of receiving a premium*
8 *subsidy if the individual is a domestic partner.]*
9 *[(6) “Qualifying event” means:]*
10 *[(a) An involuntary termination of employment during the period beginning September 1, 2008*
11 *and ending May 31, 2010; or]*
12 *[(b) On or after March 2, 2010 and before June 1, 2010, a reduction of hours that results in a*
13 *loss of coverage under a group health insurance policy.]*
14 *[(7)(a) “Transition period” means, with respect to any assistance eligible individual, any period*
15 *of coverage if:]*
16 *[(A) The involuntary termination that was the qualifying event occurred before December 19,*
17 *2009; and]*
18 *[(B) The subsidy allowed under the American Recovery and Reinvestment Act of 2009 applies to*
19 *such period due to the extension of the state continuation period to 15 months.]*
20 *[(b) Any period of time during the transition period for which the assistance eligible individual*
21 *pays the applicable premium under OAR 836-053-0866(9) shall be treated as a period of*
22 *coverage for which timely payment of premium was paid, irrespective of any failure to timely pay*
23 *the applicable premium for such period.]*
24
25 *[Stat. Auth.: ORS 731.244, 743.610 & 2009 OL Ch. 73 (HB 2433)]*
26 *[Stats. Implemented: ORS 743.610 & 2009 OL Ch. 73 (HB 2433)]*
27 *[Hist.: ID 12-2010, f. & cert. ef. 6-11-10]*
28
29 *[836-053-0861] (REPEALED)*
30 *[Notification]*
31
32 *[(1) An insurer subject to the requirements of ORS 743.610 and Chapter 73, Oregon Laws 2009*
33 *(Enrolled House Bill 2433) shall provide a notice explaining continuation of benefits directly to*
34 *individuals losing group coverage, for any reason other than group replacement of coverage,*
35 *within 10 days following the date of any administrative action taken by an insurer to initiate or*
36 *document the loss of coverage.]*
37 *[(2) The insurer providing the notice required under section (1) of this rule shall include in the*
38 *notice at least the following information:]*
39 *[(a) Contact information for the employee to reach the insurer;]*
40 *[(b) Forms and instructions about how to complete and return the forms and to whom (i.e., going*
41 *through employer or direct to insurer);]*
42 *[(c) A clear statement explaining availability of premium subsidy;]*
43 *[(d) Premium information or directions for determining the premium amount for each qualified*
44 *beneficiary and instructions for submitting the premium;]*
45 *[(e) A clear statement about who is eligible to continue coverage;]*
46 *[(f) Information about how to enroll in different coverage if allowed by the employer;]*

1 *[(g) Instructions about the employee's responsibility to notify the insurer if the employee*
2 *becomes ineligible for the subsidy; and]*
3 *[(h) Instructions about how to appeal denials for treatment as a certificate holder.]*
4 *[(3)(a) In the case of an individual who was an assistance eligible individual at any time on or*
5 *after October 31, 2009, or experiences a qualifying event (consisting of termination of*
6 *employment) relating to state continuation coverage on or after October 31, 2009, the insurer*
7 *shall provide, no later than February 17, 2010, an additional notification consisting of the*
8 *following:]*
9 *[(A) A qualifying event means involuntary termination of employment during the period of*
10 *September 1, 2008 and ending February 28, 2010;]*
11 *[(B) Assistance eligible individuals are eligible to continue coverage for a period of fifteen*
12 *months beginning with the coverage month first following the qualifying event;]*
13 *[(C) A transition period exists for assistance eligible individuals who became eligible for a*
14 *premium subsidy under the American Recovery and Reinvestment Act of 2009 before December*
15 *19, 2009 and whose state continuation coverage has now been extended to fifteen months due to*
16 *availability of the subsidy for that period of time;]*
17 *[(D) Assistance eligible individuals who did not timely pay the premium for any period of*
18 *coverage during their transition period may now pay premiums retroactively in accordance with*
19 *OAR 836-053-0866(9).*
20 *[(b) In the case of a qualifying event occurring after December 19, 2009, the insurer shall*
21 *provide notification consistent with this rule.]*
22 *[(4) In the case of an assistance eligible individual who did not timely pay the premium for any*
23 *period of coverage during the individual's transition period the insurer shall provide to the*
24 *individual, within the first 60 days of the start of the individual's transition period, an additional*
25 *notification. The additional notification shall include the information required in section (3) of*
26 *this rule and information on the ability to make retroactive premium payments in accordance*
27 *with OAR 836-053-0866(9) with respect to the transition period of the individual in order to*
28 *maintain state continuation coverage.]*
29 *[(5) In the case of an individual described in OAR 836-053-0866(11), the insurer involved shall*
30 *provide, within 10 days following the date of an individual's involuntary termination of*
31 *employment, an additional notification described in OAR 836-053-0861(2), including*
32 *information on the provisions of 836-053-0866(11).]*
33 *[(6) In the case of an individual for whom the qualifying event occurred on or after March 1,*
34 *2010 and before March 10, 2010, or on or after April 1, 2010 and before April 26, 2010, the*
35 *insurer involved shall provide the notice required under section (1) and (2) of this rule no later*
36 *than March 21, 2010, or May 17, 2010, respectively.]*
37
38 *[Stat. Auth.: ORS 731.244, 743.610 & 2009 OL Ch. 73 (HB 2433)]*
39 *[Stats. Implemented: ORS 743.610 & 2009 OL Ch. 73 (HB 2433)]*
40 *[Hist.: ID 12-2010, f. & cert. ef. 6-11-10]*
41
42 *[836-053-0866] (REPEALED)*
43 *[Provisions Relating to Premium Subsidy for State Continuation Coverage]*
44
45 *[(1) In order to maximize the benefit to Oregonians under the federal American Recovery and*
46 *Reinvestment Act of 2009 (P.L. 111-5), certain qualified beneficiaries are eligible for:*

1 *[(a) Premium subsidy for continuation of coverage;]*
2 *[(b) An opportunity to elect continuation of coverage that is in addition to the period allowed*
3 *under ORS 743.610(5);]*
4 *[(c) Continuation of coverage for a period of time that exceeds the period allowed under ORS*
5 *743.610(7)(a); and]*
6 *[(d) An option to enroll in different coverage if the employer permits certificate holders to elect*
7 *enrollment in different coverage.]*
8 *[(2) After receiving the attestation from an employer stating that the employee meets the*
9 *requirements of a certificate holder and the date of the qualifying event, an insurer is required to*
10 *accept timely payment of the certificate holder's 35 percent share of the total premium as full*
11 *payment of the premium and process claims as though 100 percent of the total premium due has*
12 *been paid.]*
13 *[(3)(a) The following certificate holders qualify for a second opportunity to elect continuation of*
14 *coverage if the group health plan remains in effect:]*
15 *[(A) Certificate holders who did not elect to continue coverage during the period allowed under*
16 *ORS 743.610(5) prior to April 28, 2009; and]*
17 *[(B) Certificate holders who elected continuation coverage during the period allowed under ORS*
18 *743.610(5) but whose continuation coverage ended for any reason prior to April 28, 2009;]*
19 *[(b) Within 31 calendar days after the insurer provides the notice required under OAR 836-053-*
20 *0861(1), certificate holders who received the notice under paragraph (a) of this section must*
21 *return the following items according to instructions provided by the insurer:]*
22 *[(A) Completed forms for electing state continuation coverage and requesting treatment as a*
23 *certificate holder;]*
24 *[(B) The individual's tax identification number;]*
25 *[(C) Form for Switching State Continuation Coverage Benefit Options, if offered; and]*
26 *[(D) The initial premium if required.]*
27 *[(c) Certificate holders who became eligible on or after September 1, 2008 and prior to April 28,*
28 *2009 are eligible to continue coverage while the group health plan remains in effect, and upon*
29 *timely payment of their portion of the premium, for 15 months of continuation coverage*
30 *beginning with the coverage month first following the qualifying event.]*
31 *[(d) The effective date for continuation coverage issued in response to a second election of*
32 *coverage will be the later of the first day of the coverage month on or after February 17, 2009 or*
33 *the first day of the coverage month first following the qualifying event.]*
34 *[(4)(a) Within 31 calendar days after the insurer provides the notice required under OAR 836-*
35 *053-0861(1), certificate holders who become eligible on or after April 28, 2009 must return the*
36 *following items according to any instructions provided by the insurer:]*
37 *[(A) Forms for electing state continuation coverage and requesting treatment as a certificate*
38 *holder;]*
39 *[(B) The individual's tax identification number;]*
40 *[(C) The form for switching state continuation coverage benefit options, if offered; and]*
41 *[(D) The initial premium, if required.]*
42 *[(b) A certificate holder who becomes eligible on or after April 28, 2009 is eligible to continue*
43 *coverage for a period of 15 months beginning with the coverage month first following the*
44 *qualifying event. However, the premium subsidy available to the individual shall not exceed any*
45 *period of limitation specified in the American Recovery and Reinvestment Act of 2009 (P.L. 111-*
46 *5)]*

1 *[(5) A certificate holder may elect to enroll in different coverage as described in section (1)(d) of*
2 *this rule if:]*
3 *[(a) The employer permits certificate holders to enroll in different coverage;]*
4 *[(b) The premium for the different coverage does not exceed the premium for coverage in which*
5 *the certificate holder was enrolled at the time of the qualifying event;]*
6 *[(c) The different coverage in which the individual elects to enroll is coverage that is also offered*
7 *to the active employees of the employer at the time the individual makes the election; and]*
8 *[(d) The different coverage is not:]*
9 *[(A) Coverage that provides only dental, vision, counseling or referral services, or a*
10 *combination of such services;]*
11 *[(B) A flexible spending arrangement as defined in section 106(c)(2) of the Internal Revenue*
12 *Code of 1986; or]*
13 *[(C) Coverage that provides coverage for services or treatments furnished in an on-site medical*
14 *facility maintained by the employer and that consists primarily of first-aid services, prevention*
15 *and wellness care or similar care, or a combination of such care.]*
16 *[(6) The period of time beginning on the date of the qualifying event and ending with the*
17 *effective date of continuation coverage shall be disregarded for purposes of determining periods*
18 *of creditable coverage under ORS 743.754, 743.737, and 743.766.]*
19 *[(7) A premium subsidy is not available to a certificate holder who becomes eligible for*
20 *coverage under any other group health plan or Medicare. An individual paying a reduced*
21 *premium for continuation coverage as described in this section must promptly notify the insurer*
22 *if they become eligible for other group health plan coverage or Medicare.]*
23 *[(8) Certificate holders who elected continuation on or after September 1, 2008 and prior to*
24 *April 28, 2009, are eligible to continue coverage while the group health plan remains in effect,*
25 *and upon timely payment of their portion of the premium, for a period of 15 months beginning*
26 *with the coverage month first following the qualifying event.]*
27 *[(9) In the case of any premium for a period of coverage during an assistance eligible*
28 *individual's transition period, the individual shall be treated for purposes of any state*
29 *continuation provision as having timely paid the amount of such premium if:]*
30 *[(a) The individual was covered under the state continuation coverage to which the premium*
31 *relates for the period of coverage immediately preceding the transition period; and]*
32 *[(b) The individual pays the individual's 35 percent share of the total premium:]*
33 *[(A) Not later than February 17, 2010; or]*
34 *[(B) If the transition period extends beyond February 17, 2010, not later than 30 days after the*
35 *date notification required under OAR 836-053-0861(4) is provided to the individual.]*
36 *[(10) In the case of an assistance eligible individual who pays, with respect to any period of state*
37 *continuation coverage during the individual's transition period, the full premium amount for*
38 *such coverage, the insurer shall:]*
39 *[(a) Make a reimbursement payment to the individual for the amount of premium paid in excess*
40 *of the 35 percent share of the total premium; or*
41 *[(b) Provide credit to the individual for the amount in a manner that reduces one or more*
42 *subsequent premium payments that the individual is required to pay for the coverage involved.]*
43 *(11)(a) For the purposes of the state continuation provisions under ORS 743.610, in the case of*
44 *an individual who did not make, or who made and discontinued, an election of state continuation*
45 *coverage on the basis of the reduction of hours of employment, the involuntary termination of*
46 *employment of the individual on or after March 2, 2010 shall be treated as a qualifying event.]*

1 *[(b) In any case of an individual referred to in subsection (a) of this section, the period of the*
2 *individual's continuation coverage shall be determined as though the qualifying event were the*
3 *reduction of hours of employment.]*

4 *[(c) Nothing in this section shall be construed as requiring an individual referred to in*
5 *subsection (a) of this section to make a payment for state continuation coverage between the*
6 *reduction of hours and the involuntary termination of employment.]*

7 *[(d) The period of time beginning on the date of the qualifying event described in this section and*
8 *ending with the effective date of continuation coverage shall be disregarded for purposes of*
9 *determining periods of creditable coverage under ORS 743.754, 743.737, and 743.766.]*

10 *[(e) The provisions of this section apply to individuals who are assistance eligible individuals on*
11 *the basis of a qualifying event consisting of a reduction of hours occurring during the period that*
12 *begins with September 1, 2008, and ends with May 31, 2010, followed by an involuntary*
13 *termination of employment that occurred on or after March 2, 2010 and before June 1, 2010.]*

14
15 *[Stat. Auth.: ORS 731.244, 743.610 & 2009 OL Ch. 73 (HB 2433)]*

16 *[Stats. Implemented: ORS 743.610 & 2009 OL Ch. 73 (HB 2433)]*

17 *[Hist.: ID 12-2010, f. & cert. ef. 6-11-10]*

18
19 **Quality Assessment and Improvement**

20
21 **836-053-1000 (AMENDED)**

22 **Statutory Authority and Implementation**

23
24 (1) OAR 836-053-1000 to 836-053-1200 are adopted under the authority of ORS 731.244,
25 743.814, and 743.819, for the purpose of implementing ORS 743.804, 743.807, 743.814,
26 743.817, 743.819, 743.821, 743.829, 743.837 and 743A.012. The filing and reporting
27 requirements in this rule and in OAR 836-053-1070, 836-053-1130, 836-053-1170, and 836-053-
28 1190 apply to all domestic insurers transacting health benefit plans, including health care service
29 contractors, to all foreign carriers transacting health benefit plans who transacted \$2 million or
30 more in annual health benefit plan premium in Oregon, and to other carriers transacting health
31 benefit plans as determined by the Director **of the Department of Consumer and Business**
32 **Services.**

33 (2) When an insurer maintains more than one type of health benefit plan, the insurer shall
34 comply with OAR 836-053-1000 to 836-053-1200 on a plan-by-plan basis.

35 (3) Not later than June 30 of each year, each insurer shall file with the director for the
36 immediately preceding calendar year the following information as required of the insurer:

37 (a) An annual summary of the insurer's aggregate data relating to grievances, appeals and
38 applications for external review, required by ORS 743.804[(9)] of all insurers;

39 (b) An annual summary relating to the insurer's utilization review policies, required by ORS
40 743.807(1) of each insurer that provides utilization review or has utilization review provided on
41 its behalf;

42 (c) An annual summary relating to the insurer's quality assessment activities required by ORS
43 743.814(2) of each insurer that offers managed health insurance;

44 (d) The results of all publicly available federal Health Care Financing Administration reports and
45 accreditation surveys by national accreditation organizations required by ORS 743.814(3)(a) of
46 each insurer that offers managed health insurance;

1 (e) The insurer's health promotion and disease prevention activities, if any, including a summary
2 of screening and preventive health care activities covered by the insurer, required by ORS
3 743.814(3)(b) of each insurer that offers managed health insurance. The insurer may submit the
4 summary required in this subsection in the format of the insurer's choosing, including a
5 summary prepared for another purpose. The summary required in this subsection shall include
6 the following activities, to the extent the insurer engages in them, and may include any additional
7 information that the insurer deems significant in describing its health promotion and disease
8 prevention activities:
9 (A) Tobacco use and cessation;
10 (B) Cancer screening, including mammography;
11 (C) Diabetes education and home monitoring;
12 (D) Immunizations;
13 (E) Childbirth education and parenting support;
14 (F) Nutrition;
15 (G) Cardiovascular health; and
16 (H) Injury prevention; and
17 (f) An annual summary relating to the scope of the insurer's network and to the accessibility of
18 services, required by ORS 743.817(1) of each insurer that offers managed health insurance.
19 (4) In order to minimize duplicative reporting requirements, an insurer may submit a copy of a
20 report prepared for a national accreditation organization to meet the reporting requirements of
21 section (3)(e) of this rule relating to the insurer's health promotion and disease prevention
22 activities, OAR 836-053-1130(1) relating to the insurer's utilization review policies, OAR 836-
23 053-1170(1) relating to the insurer's quality assessment activities and OAR 836-053-1190(1)
24 relating to the insurer's provider network and the accessibility of services. To the extent that a
25 report prepared for a national accreditation organization does not include information required by
26 the department, the insurer must submit an addendum to the report that provides this information.
27 (5) If information required to be filed annually with the department pursuant to this rule has not
28 changed since an insurer's previous annual filing, an insurer may satisfy the reporting
29 requirements of this rule by indicating that the information has not changed, or if some but not
30 all information has changed, by submitting an addendum to the previous annual filing indicating
31 only the information that has changed since the previous filing. However, every third year the
32 insurer must file all required information, including information that may not have changed since
33 the previous filing. For example, if an insurer made an annual filing in 1998, it is sufficient to
34 indicate in 1999 and 2000 that certain information has not changed since the previous annual
35 filing or to submit an addendum indicating the information that has changed, but the filing in
36 2001 must contain all information required by the department pursuant to this rule.
37 (6) All filings required in section (3) of this rule must be made electronically.
38 (7) For purposes of OAR 836-053-1000 to 836-053-1200, "insurer" also includes a health care
39 service contractor as defined in ORS 750.005 and a multiple employer welfare arrangement as
40 defined in ORS 750.301.
41 (8) OAR 836-053-1000 to 836-053-1200 apply to a self-insured public entity to the extent
42 provided in ORS 731.036.
43 (9) An insurer shall administer the plan in compliance with ORS 743.804, 743.807, 743.814,
44 743.817, 743.821, 743.829, 743.837 and 743A.012 and OAR 836-053-1000 to 836-053-1200.

1 (10) An insurer shall comply with the federal Newborns' and Mothers' Health Protection Act of
2 1996, as referred to in ORS 743.823 with respect to group health insurance plans and individual
3 health insurance plans.

4
5 Stat. Auth.: ORS 731.244, 743.814 & 743.819

6 Stats. Implemented: ORS 743.804, 743.807, 743.814, 743.817, 743.819, 743.821, 743.829,
7 743.837 & 743A.012

8 Hist.: ID 1-1998, f. & cert. ef. 1-15-98; ID 5-2000, f. & cert. ef. 5-11-00; ID 15-2010, f. & cert.
9 8-19-10

10
11 836-053-1030 (AMENDED)

12 Written Information to Enrollees

13
14 (1) Each insurer must furnish the written general information to policyholders that is required by
15 ORS 743.804[(2)], **including but not limited to information** relating to enrollee rights and
16 responsibilities, **including the right to appeal adverse benefit determinations**, [and
17 743.804(5), relating to] services, access thereto and related charges and scheduling, **and access**
18 **to external review**, as provided in this rule. An insurer:

19 (a) Must furnish the information regarding an individual health insurance policy to each
20 policyholder; and

21 (b) Must furnish the information regarding a group health insurance policy to the group
22 policyholder for distribution to enrollees of the group policy.

23 (2) **(a)** The written general information referred to in section (1) of this rule must be included
24 either in the policy or in other [material] **evidence of coverage** that is delivered to the **individual**
25 **policyholder by the insurer, or in the case of a group health insurance policy, that is**
26 **delivered by the insurer to the group policyholder for distribution to enrollees.**

27 **(b) For purposes of ORS 743.804(2)(g), "continued coverage under the health benefit plan"**
28 **means coverage of an ongoing course of treatment previously approved by the insurer.**

29 **(c) The information required under subsection (a) of this section must include all of the**
30 **following:**

31 **(A) A description of the external review process, including when external review is**
32 **available and how to request external review. The description must include the phone**
33 **number of the Oregon Insurance Division.**

34 **(B) A disclosure that when filing a request for an external review the enrollee will be**
35 **required to authorize the release of any records, including medical records of the covered**
36 **person that may be required to be reviewed for the purpose of reaching a decision on the**
37 **external review.**

38 **(C) A disclosure that the enrollee is financially responsible for benefits paid to or on behalf**
39 **of an enrollee pursuant to ORS 743.804(2)(g) if the insurer's adverse benefit determination**
40 **is upheld on appeal.**

41 **(D) A disclosure that the enrollee may request and receive from the insurer the information**
42 **the insurer is required to disclose under ORS 743.804 (5).**

43 (3) The written general information must disclose the following in relation to referrals for
44 specialty care, behavioral health services, hospital services and other services, in addition to
45 other relevant information regarding referrals:

1 (a) If applicable, how gate keeping or access controls apply to referrals and whether and how the
2 controls differ for specialty care, behavioral health services and hospital services; and
3 (b) Any limitation on referrals if a plan has a defined network of participating providers and if
4 referrals for specialty care may be limited to a portion of the network, such as to those specialists
5 who contract with an enrollee's primary care group.
6 (4) The written general information must include the information required by ORS 743.699,
7 relating to coverage of emergency medical conditions and obtaining emergency services,
8 including a statement of the prudent layperson standard for an emergency medical condition, as
9 that term is defined in 743.801. An insurer may meet the requirement of providing information in
10 743.699 by providing adequate disclosure in the written general information required by
11 743.804(5) and this rule. An insurer may use the following statement regarding the use of the
12 emergency telephone number 9-1-1, or other wording that appropriately discloses its use:
13 If you or a member of your family needs immediate assistance for a medical emergency, call 9-
14 1-1 or go directly to an emergency room.
15 (5) The written general information must include information regarding the use of the insurer's
16 grievance process, including the assistance available to enrollees in filing written grievances in
17 accordance with OAR 836-053-1090 and the utilization review appeal procedures required by
18 ORS 743.807(2)(c). The information must be contained in a separate section of the written
19 information and captioned in a manner that clearly indicates that the section addresses grievances
20 and appeals.
21 (6) The written general information must include a notice that states the right to file a complaint
22 with or seek assistance from the Director of the Department of Consumer and Business Services.
23 An insurer may use the following statement or other appropriate wording for this purpose:
24 You have the right to file a complaint or seek other assistance from the Oregon
25 **[agency]Insurance Division**. Assistance is available:
26 *[By calling (503) 947-7984 or the toll free message line at (888) 877-4894;]*
27 *[By writing to the Oregon agency, Consumer Protection Unit,*
28 *350 Winter Street NE, Room 440-2,] Salem, OR 97301-3883;]*
29 *[Through the Internet at <http://www.cbs.state.or.us/external/ins/>; or]*
30 *[By e-mail at: DCBS.INSMAIL@state.or.us]*
31 **By calling (503) 947-7984 or the toll free message line at (888) 877-4894.**
32 **By writing to the Oregon Division of Insurance, Consumer Advocacy Unit,**
33 **PO Box 14480; Salem, OR 97309-0405.**
34 **Through the Internet at <http://www.insurance.oregon.gov/consumer/consumer.html>.**
35 **By e-mail at: cp.ins@state.or.us**
36 (7) The written general information for an insurance policy providing managed health care must
37 include a description of the procedures by which enrollees, purchasers and providers may
38 participate in the development and implementation of insurer policy and operation.
39 (8) The portion of the written general information that describes how an insurer makes decisions
40 regarding coverage and payment for treatment or services must include a notice to enrollees that
41 they may request an additional written summary of information that the insurer may consider in
42 its utilization review of a particular condition to the extent the insurer maintains such criteria.
43 The notice to enrollees must include the name and telephone number of the administrative
44 section of the insurer that handles enrollee requests for information.
45 (9) If a plan has a defined network of participating providers, the written general information
46 must include a list of all primary care providers and direct access providers, and may also

1 include a list of all specialty care providers. For the purposes of this section, a primary care
2 provider or direct access provider is a participating provider under the terms of the plan who an
3 enrollee may designate as the primary care provider for the enrollee or from whom an enrollee
4 may obtain services without referral. The list of providers must include for each provider the
5 provider's name, professional designation, category of practice and the city in which the practice
6 of the provider is located. If the information does not list participating specialty care providers,
7 the information must state that fact and must disclose the manner in which an enrollee may
8 obtain information about participating specialty care providers.

9 (10) If a plan includes risk-sharing arrangements with physicians or other providers, the written
10 general information must contain a statement to that effect, including a brief description of risk-
11 sharing in general, and must notify enrollees that additional information is available upon
12 request. For the purpose of this requirement, a risk-sharing arrangement does not include a fee-
13 for-service arrangement or a discounted fee-for-service arrangement. An insurer may use the
14 following statement to describe risk-sharing, or other appropriate wording:

15 This plan includes "risk-sharing" arrangements with physicians who provide services to the
16 members of this plan. Under a risk-sharing arrangement, the providers that are responsible for
17 delivering health care services are subject to some financial risk or reward for the services they
18 deliver. An example of a risk sharing arrangement is a contract between an insurer and a group
19 of heart surgeons in which the surgeons agree to provide all of the heart operations needed by
20 plan members and the insurer agrees to pay a fixed monthly amount for those services.

21 (11) If the insurer of a plan uses a mandatory closed formulary, the written general information
22 for that plan must prominently disclose and explain the formulary provision. The disclosure and
23 explanation must be in boldfaced type or otherwise emphasized.

24 (12) The written general information must include a notice disclosing that additional information
25 is available to enrollees upon request to the insurer. The notice must include the name and
26 telephone number of the insurer's administrative section that handles enrollee requests for
27 information. For the notice required in the written general information disclosing information
28 available from the Department of Consumer and Business Services, an insurer may use the
29 following statement, or other appropriate wording:

30 The following information regarding the health benefit plans of (insurer's name) is available
31 from the Oregon agency:

- 32 1. An annual summary of grievances and appeals;
- 33 2. (if applicable) An annual summary of utilization review policies;
- 34 3. (if applicable) An annual summary of quality assessment activities;
- 35 4. (if applicable) The results of all publicly available accreditation surveys;
- 36 5. (if applicable) An annual summary of the insurer's health promotion and disease prevention
37 activities;
- 38 6. (if applicable) An annual summary of scope of network and accessibility of services.

39 This information is available:

40 *[By calling (503) 947-7984 or the toll free message line at (888) 877-4894;]*

41 *[By writing to the Oregon agency, Consumer Protection Unit,
42 350 Winter Street NE, Room 440-2, Salem, OR 97301-3883;]*

43 *[Through the Internet at <http://www.cbs.state.or.us/external/ins/>; or]*

44 *[By e-mail at: DCBS.INSMAIL@state.or.us]*

45 **By calling (503) 947-7984 or the toll free message line at (888) 877-4894.**

46 **By writing to the Oregon Division of Insurance, Consumer Advocacy Unit,**

1 **PO Box 14480; Salem, OR 97309-0405.**
2 **Through the Internet at <http://www.insurance.oregon.gov/consumer/consumer.html>.**
3 **Or by e-mail at: cp.ins@state.or.us**
4

5 Stat. Auth.: ORS 731.244 **and 743.857**
6 Stats. Implemented: ORS 743.699, ORS 743.804 & ORS 743.807
7 Hist.: ID 1-1998, f. & cert. ef. 1-15-98; ID 5-2000, f. & cert. ef. 5-11-00; ID 11-2011(Temp), f.
8 & cert. ef. 7-7-11 thru 12-21-11
9

10 **836-053-1033 (NEW)**
11 **Cultural and Linguistic Appropriateness**
12

13 **(1) All notices and communications required to be provided by an insurer to enrollees**
14 **under ORS 743.804 and ORS 743.857 must be provided in a manner that is culturally and**
15 **linguistically appropriate, as required by ORS 743.804. For purposes of this section, an**
16 **insurer is considered to provide relevant notices in a culturally and linguistically**
17 **appropriate manner if the plan or issuer meets all the following requirements with respect**
18 **to the applicable non-English languages as described in section (2) of this rule:**

19 **(a) The plan or issuer must provide oral language services (such as a telephone customer**
20 **assistance hotline) that include answering questions in any applicable non-English**
21 **language and providing assistance with filing claims and appeals (including external**
22 **review) in any applicable non-English language.**

23 **(b) The plan or issuer must provide, upon request, a notice in any applicable non-English**
24 **language.**

25 **(c) The plan or issuer must include in the English versions of all notices, a statement**
26 **prominently displayed in any applicable non-English language clearly indicating how to**
27 **access the language services provided by the plan or issuer.**

28 **(2) For the purpose of this rule, “applicable non-English language” means, with respect to**
29 **an address in any United States county to which a notice is sent, a non-English language for**
30 **which ten percent or more of the population residing in the county is literate only in the**
31 **same non-English language.**
32

33 **Stat. Auth.: ORS 731.244 and 743.804**
34 **Stats. Implemented: ORS 743.804**
35

36 **836-053-1035 (New)**
37 **Summary of Benefits and Explanation of Coverage**
38

39 **The summary of benefits and explanations of coverage required by ORS 743.804 must be**
40 **provided in a manner and form consistent with the requirements of 45 CFR 147.200 as set**
41 **forth on August 22, 2011.**
42

43 **Stat. Auth.: ORS 731.244 and 743.804.**
44 **Stats. Implemented: ORS 743.804.**
45

46 836-053-1060 (AMENDED)

1 Definitions

2
3 For purposes of grievance procedures under OAR 836-053-1000 to 836-053-1200, and ORS
4 743.804:

5 (1) "Complaint" means an expression of dissatisfaction **directly** to an insurer that is about a
6 specific problem encountered by an enrollee or about a decision by an insurer or by an insurance
7 producer acting on behalf of the insurer and that includes a request for action to resolve the
8 problem or change the decision. "Complaint" does not include an inquiry as that term is defined
9 in this rule.

10 (2) [*"Grievance" has the meaning given in ORS 743.801, which states that "grievance" means a*
11 *written complaint submitted by or on behalf of an enrollee regarding:*]

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

14 [*(b) Claims payment, handling or reimbursement for health care services; or*]

15 [*(c) Matters pertaining to the contractual relationship between an enrollee and an insurer.*]

16 [(3)] "Inquiry" means a written request for information or clarification about any subject matter
17 related to the enrollee's health benefit plan.

18
19 Stat. Auth.: ORS 731.244 & 743.819

20 Stats. Implemented: ORS 743.801 & 743.804

21 Hist.: ID 1-1998, f. & cert. ef. 1-15-98; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05

22
23 836-053-1070 (AMENDED)

24 Reporting of Grievances; Format and Contents

25
26 (1) For the purpose of complying with the requirement in ORS 743.804[(9)] that each insurer
27 provide an annual summary of the insurer's aggregate data regarding grievances, appeals and
28 applications for external review, an insurer must report the data required in section (2) of this
29 rule for grievances closed in the previous calendar year ending December 31. The data must be
30 reported in a format prescribed by the Director **of the Department of Consumer and Business**
31 **Services**. For purposes of this rule:

32 [*(a) The number of grievances means the total number of written complaints closed by the*
33 *insurer that qualify as a "grievance" as that term is defined in ORS 743.801; and]*

34 [*(b) a grievance is "closed" if:*]

35 [*(A) The insurer has made a determination regarding the grievance and the complainant has not*
36 *appealed the determination;*]

37 [*(B) (a) The grievance has been appealed through all available grievance appeal levels; or*

38 [*(C) (b) The insurer determines that the complainant is no longer pursuing the grievance.*]

39 (2) The data to be included in the annual summary are as follows:

40 (a) The total number of grievances closed in the reporting year;

41 (b) The number of grievances closed in each of the categories listed in section (3) of this rule;

42 (c) The number and percentage of grievances in each of the categories listed in section (3) of this
43 rule in which the insurer's initial decision is upheld and the number and percentage in which the
44 initial decision is reversed at closure of the grievance;

45 [*(d) The number and percentage of all grievances that are closed at the initial grievance stage;*]

1 [(e)] **(d)** The number and percentage of all grievances that are closed at the **conclusion of the**
2 first level of appeal;

3 [(f)] **(e)** The number and percentage of all grievances that are closed at the **conclusion of the**
4 second level of appeal;

5 [(g)] **(f)** The number and percentage of all grievances that result in applications for external
6 review; and

7 [(h)] **(g)** For each [stage of a grievance or] level of appeal listed in subsections (d) [to (f)] **and (e)**
8 of this section, the average length of time between the date an enrollee files [a grievance or] **the**
9 appeal and the date an insurer sends written notice of the insurer's determination for that [stage
10 of the grievance or level of] appeal to the enrollee, or person filing the [grievance or] appeal on
11 behalf of [an] **the** enrollee.

12 (3) An insurer must report each grievance according to the nature of the grievance. The nature of
13 the grievance shall be determined according to the categories listed in this section. The insurer
14 must report each grievance in one category only and must have a system that allows the insurer
15 to report accurately in the specified categories. If a grievance could fit in more than one category,
16 an insurer shall report the grievance in the category established in this section that the insurer
17 determines to be most appropriate for the grievance. The categories of grievances are as follows:

18 [(a) Access problems, including timeliness and the availability of a provider;]
19 [(b) Denials based on medical necessity;]
20 [(c) Denials based on other coverage issues, including denials based on the service being out of
21 plan, out of area or not a covered benefit;]
22 [(d) Eligibility;]
23 [(e) Quality of clinical care;]
24 [(f) Quality of plan services, not including the quality of clinical care as provided in
25 subsection[(e) of this section;]
26 [(g) Referral issues;]

27 **(a) Adverse benefit determinations based on medical necessity under ORS 743.857;**
28 **(b) Adverse benefit determinations based on an insurer's determination that a plan or**
29 **course of treatment is experimental or investigational under ORS 743.857;**
30 **(c) Continuity of care as defined in ORS 743.854;**
31 **(d) Access and referral problems including timelines and availability of a provider and**
32 **quality of clinical care;**
33 **(e) Whether a course or plan of treatment is delivered in an appropriate health care setting**
34 **and with the appropriate level of care;**
35 **(f) Adverse benefit determinations of otherwise covered benefits due to imposition of a**
36 **preexisting condition exclusion, source-of-injury exclusion, out-of-network or out-of-plan**
37 **exclusion, annual benefit limits or other limitations of otherwise covered benefits;**
38 **(g) Adverse benefit determinations based on general exclusions, not a covered benefit or**
39 **other coverage issues not listed in this section;**
40 **(h) Eligibility for, or termination of enrollment, rescission or cancelation of a policy or**
41 **certificate;**
42 **(i) Quality of plan services, not including the quality of clinical care as provided in**
43 **subsection (d) of this section;**

44 [(h)] **(j)** Emergency services; and
45 [(i)] **(k)** Administrative issues and issues other than those otherwise listed in this section.

1 (4) Nothing in this rule prohibits an insurer from creating or using its own system to categorize
2 the nature of grievances in order to collect data if the system allows the insurer to report
3 grievances accurately according to the categories in section (3) of this rule and if the system
4 enables the director to track the grievances accurately.

5
6
7 Stat. Auth.: ORS 731.244 & 732.819

8 Stats. Implemented: ORS 743.804

9 Hist.: ID 1-1998, f. & cert. ef. 1-15-98; ID 15-2010, f. & cert. 8-19-10

10
11 836-053-1080 (AMENDED)

12 Tracking Grievances

13
14 An insurer shall record data relating to all grievances, significant actions taken from each initial
15 grievance filing through the appeals process, and applications for external review as required by
16 ORS 743.804, in a manner sufficient for the insurer to report grievances accurately as required
17 by ORS 743.804 and OAR 836-053-1070, and for the insurer to track individual files in response
18 to a market conduct examination or other inquiry by the Director **of the Department of**
19 **Consumer and Business Services** under ORS 733.170 and OAR 836-080-0215. **In accordance**
20 **with ORS 743.804, records documenting grievances must be maintained for a period of at**
21 **least six years after the date the record is generated.**

22
23 Stat. Auth.: ORS 731.244 & 743.819

24 Stats. Implemented: ORS 743.804

25 Hist.: ID 1-1998, f. & cert. ef. 1-15-98; ID 15-2010, f. & cert. 8-19-10

26
27 836-053-1100 (AMENDED)

28 *[Time Requirements for Grievance Review]* **Internal Appeals Process**

29
30 (1) The minimum standards for timeliness of response by an insurer to [*grievances and*] appeals
31 by its enrollees, for purposes of the system of resolving [*grievances*] and appeals required by
32 ORS 743.804 are as follows:

33 (a) An insurer shall acknowledge receipt of an [*initial grievance or the first or second*] appeal
34 from an enrollee not later than the seventh day after receiving the [*grievance or the first or*
35 *second*] appeal;

36 (b) An insurer shall make a decision on the [*initial grievance or the first or second*] appeal not
37 later than the 30th day after receiving notice of the [*initial grievance or the*] appeal. [*In the event*
38 *of an initial grievance, the insurer may have an additional 15 days to resolve the issue if before*
39 *the 30th day the insurer gives a notice of delay to the enrollee or representative of the enrollee*
40 *that includes a specific reason for the delay.*]

41 (2) An otherwise applicable standard for timeliness in section (1) of this rule does not apply
42 when:

43 (a) The period of time is too long to accommodate the clinical urgency of the situation;

44 (b) The enrollee does not reasonably cooperate; or

1 (c) Circumstances beyond the control of a party prevent that party from complying with the
2 standard, but only if the party who is unable to comply gives notice of the specific circumstances
3 to the other party when the circumstances arise.

4 [(3) *An insurer shall treat an appeal from a decision by a medical consultant or peer review*
5 *committee pursuant to OAR 836-053-1140(1)(b) as a second appeal under the insurer's*
6 *grievance procedures under ORS 743.804(3).]*

7 **[(4)] (3) For adverse benefit determinations eligible for external review under ORS 743.857,**
8 **an insurer may waive its internal appeals process at any time. If the insurer waives its**
9 **internal appeals process, the internal appeals process is deemed exhausted for the purposes**
10 **of qualifying for external review.**

11 Stat. Auth.: ORS 731.244

12 Stats. Implemented: ORS 743.804

13 Hist.: ID 1-1998, f. & cert. ef. 1-15-98; ID 5-2000, f. & cert. ef. 5-11-00; ID 11-2011(Temp), f.
14 & cert. ef. 7-7-11 thru 12-21-11

15 836-053-1110 (AMENDED)

16 Notice of Complaint Filing with Director

17 (1) A written decision by an insurer in response to a grievance, a first appeal and a second appeal
18 must prominently disclose the following:

19 You have the right to file a complaint or seek other assistance from the Oregon agency.

20 Assistance is available:

21 [By calling (503) 947-7984;]

22 [By writing to the Oregon agency, Consumer Protection Unit, 350 Winter Street NE, Room 440-
23 2, Salem, OR 97310; or]

24 [Through the Internet at [http://www.cbs.state.or.us/external/ins/.](http://www.cbs.state.or.us/external/ins/)]

25 **By calling (503) 947-7984 or the toll free message line at (888) 877-4894.**

26 **By writing to the Oregon Division of Insurance, Consumer Advocacy Unit,**
27 **PO Box 14480; Salem, OR 97309-0405.**

28 **Through the Internet at <http://www.insurance.oregon.gov/consumer/consumer.html>.**

29 **Or by e-mail at: cp.ins@state.or.us**

30 (2) The information stated in section (1) of this section is subject to change upon notice from the
31 Director **of the Department of Consumer and Business Services.**

32 Stat. Auth.: ORS 731.244

33 Stats. Implemented: ORS 743.804

34 Hist.: ID 1-1998, f. & cert. ef. 1-15-98

35 836-053-1140 (AMENDED)

36 Appeal, Utilization Review Determinations

37 (1) When a [*patient or a*] provider first appeals the decision of an insurer to deny treatment or
38 payment for services as not medically necessary or experimental under ORS 743.807(2)(c):

39 (a) The insurer shall acknowledge receipt of the notice of appeal not later than the seventh day
40 after receiving the notice; and

- 1 (b) An appropriate medical consultant or peer review committee shall review the appeal and
2 decide the issue not later than the 30th day after the insurer receives notice of the appeal.
3 (2) A standard for timeliness in section (1) of this rule does not apply when:
4 (a) The period of time is too long to accommodate the clinical urgency of the situation;
5 (b) The [*patient or*] provider does not reasonably cooperate; or
6 (c) Circumstances beyond the control of a party prevent that party from complying with the
7 standard, but only if the party who is unable to comply gives notice of the specific circumstances
8 to the other party when the circumstances arise.
9 (3) An insurer shall treat an appeal from a decision by a medical consultant or peer review
10 committee pursuant to section (1)(b) of this rule as [*a second appeal*] **an internal appeal** under
11 the insurer's grievance procedures under ORS 743.804(3).
12 (4) Nothing in this rule shall prevent [*a patient*] **an enrollee** from filing [*a grievance*] **an**
13 **internal appeal** under the insurer's regular grievance procedure established pursuant to ORS
14 743.804[(3)] when the grievance concerns an [*insurer's denial of treatment or payment for*
15 *services as not medically necessary or as experimental*] **adverse benefit determination**, but this
16 rule does not entitle a person not otherwise allowed to file a grievance or to appeal a decision by
17 a medical consultant or peer review committee to file such a grievance or appeal.

18
19 Stat. Auth.: ORS 731.244

20 Stats. Implemented: ORS 743.804 [*&ORS*] , **743.806** & 743.807

21 Hist.: ID 1-1998, f. & cert. ef. 1-15-98
22

23 Independent Review

24
25 836-053-1310 (AMENDED)

26 Contracting Requirements
27

- 28 (1) To be considered for contracting with the Director **of the Department of Consumer and**
29 **Business Services** as an independent review organization under ORS 743.858 for the purpose of
30 providing independent review under **ORS** 743.857, an independent review organization must
31 submit to the director a response to the director's request for proposal according to its
32 requirements. The response must include:
33 (a) For an independent review organization that is publicly held, the name of each stockholder or
34 owner of more than five percent of any stock or options;
35 (b) The name of any holder of bonds or notes of the independent review organization that exceed
36 \$100,000;
37 (c) The name and type of business of each corporation or other organization that the independent
38 review organization controls or is affiliated with and the nature and extent of the affiliation or
39 control;
40 (d) The name and a biographical sketch of each director, officer and executive of the independent
41 review organization and any entity listed under subsection (c) of this section and a description of
42 any relationship the named individual has with:
43 (A) An insurer;
44 (B) A utilization review agent;
45 (C) A nonprofit or for-profit hospital or other health care corporation;
46 (D) A doctor of medicine or osteopathy, a provider or other health care professional;

- 1 (E) A drug or device manufacturer; or
2 (F) A group representing any of the entities described by paragraph (A) to (E) of this subsection;
3 (e) The percentage of the independent review organization's revenues that the independent
4 review organization anticipates will be derived from reviews conducted under ORS 743.862;
5 (f) A description of the areas of expertise of the medical reviewers making review determinations
6 for the independent review organization, as well as policies and standards of the independent
7 review organization that address qualifications, training and assignment of all types of medical
8 reviewers and that are compliant with requirements of OAR 836-053-1317;
9 (g) The procedures that the independent review organization will use in making review
10 determinations regarding reviews conducted under ORS 743.862;
11 (h) Attestations that all requirements will be met;
12 (i) Evidence of [*accreditations, certifications and government independent review organization*
13 *contracts that the independent review organization relies upon to demonstrate compliance with*
14 *applicable requirements of ORS 743.862 and OAR 836-053-1315*] **accreditation by a nationally**
15 **recognized private accrediting organization**;
16 (j) Other documentation, including but not limited to legal and financial information, policies
17 and procedures, and data that are pertinent to requirements of ORS 743.862 and OAR 836-053-
18 1315; and
19 (k) Any other requirements established by the director that demonstrate the independent review
20 organization's ability to meet all requirements for contracting as an independent review
21 organization in this state.
22 (2) In order to enable the director to consider the response of an independent review organization
23 under section (1) of this rule:
24 (a) The independent review organization must authorize release of information from primary
25 sources, including full reports of site visits, inspections and audits; and
26 (b) The Director may require the independent review organization to indicate which documents
27 demonstrate compliance with specific statutory requirements under ORS 743.862 and OAR 836-
28 053-1315.
29 (3) Investigation and verification activities of the director regarding the independent review
30 organization may include, but are not limited to:
31 (a) Review of the response of the independent review organization to the request for proposals
32 and its filings for completeness and compliance with standards;
33 (b) On-site survey or examination;
34 (c) Primary-source verification with accreditation or regulatory bodies of compliance with
35 requirements that are used to demonstrate compliance with applicable standards established in
36 ORS 743.862 and OAR 836-053-1315; and
37 (d) Other means of determining regulatory and accreditation histories.

38
39 Stat. Auth.: ORS 731.244, 743.857 & 743.858

40 Stats. Implemented: ORS 743.858

41 Hist.: ID 10-2002(Temp), f. & cert. ef. 4-5-02 thru 9-27-02; ID 19-2002, f. 9-27-02, cert. ef. 9-
42 28-02; ID 11-2011(Temp), f. & cert. ef. 7-7-11 thru 12-21-11

43
44 836-053-1340 (AMENDED)

45 Timelines and Notice for Dispute that is Not Expedited

46

1 (1) An insurer shall give the Director **of the Department of Consumer and Business Services**
2 notice of an enrollee's request for independent review by delivering a copy of the request to the
3 director not later than the second business day of the insurer after the insurer receives the request
4 for the independent review. **In the event the enrollee applies to the director rather than to the**
5 **insurer for independent review, the director shall provide the insurer notice of the**
6 **enrollee's request for independent review by delivering a copy of the request to the insurer**
7 **not later than the next business day of the department after the director receives the**
8 **request for independent review.**

9 (2) If an insurer reverses its final adverse determination before expiration of the deadline for
10 sending the notice to the director under section (1) of this rule, the insurer must notify the
11 enrollee not later than the next business day of the insurer after its reversal. The notice to the
12 enrollee may be given electronically, by facsimile or by telephone, followed by a written
13 confirmation.

14 (3) Not later than the next business day of the department after the director has received a request
15 for independent review from an insurer **or an enrollee**, the director shall assign the review to one
16 of the independent review organizations with whom the director has contracted. The director
17 shall notify the insurer in writing of the name and address of the independent review
18 organization to which the request for the independent review should be sent. If sending written
19 notice will unduly delay notification, the director shall give the notice electronically, by
20 facsimile or by telephone, followed by a written confirmation.

21 (4) The director shall notify the enrollee, not later than the second business day of the department
22 after the director gave notice under section (3) of this rule of the assignment of the request. The
23 notice must include a written description of the independent review organization selected to
24 conduct the independent review and information explaining how the enrollee may provide the
25 director with documentation regarding any potential conflict of interest of the independent
26 review organization as described in OAR 836-053-1320.

27 (5) Not later than the third calendar day following receipt of notice from the director under
28 section (4) of this rule, or the subsequent business day of the department if any of the days is not
29 a normal business day of the department, the enrollee may provide the director with
30 documentation regarding a potential conflict of interest of the independent review organization.
31 The documentation shall be sent in written form. If sending written documentation will unduly
32 delay the process, the enrollee shall give the notice electronically, by facsimile or by telephone,
33 followed by a written confirmation. If the director determines that the independent review
34 organization presents a conflict of interest as described in OAR 836-053-1320, the director shall
35 assign another independent review organization not later than the next business day of the
36 department. The director shall notify the insurer of the new independent review organization to
37 which the request for the independent review should be sent. The director shall also notify the
38 enrollee of the director's determination regarding the potential conflict of interest and the name
39 and address of the new independent review organization.

40 (6) Not later than the sixth business day of the insurer after the date on which the insurer
41 received notice from the director under section (3) of this rule, the insurer shall deliver to the
42 assigned independent review organization the following documents and information considered
43 in making the insurer's final adverse decision, including the following:

44 (a) Information submitted to the insurer by a provider or the enrollee in support of the request for
45 coverage under the health benefit plan's procedures.

1 (b) Information used by the health benefit plan during the internal appeal process to determine
2 whether the course or plan of treatment is:
3 (A) Medically necessary;
4 (B) Experimental or investigational; or
5 (C) An active course of treatment for purposes of continuity of care.
6 (c) A copy of all denial letters issued by the plan concerning the case under review.
7 (d) A copy of the signed waiver form, or a waiver, authorization or consent that is otherwise
8 permitted under the federal Health Insurance Portability and Accountability Act or other state or
9 federal law, authorizing the insurer to disclose protected health information, including medical
10 records, concerning the enrollee that is pertinent to the independent review.
11 (e) An index of all submitted documents.
12 (7) Not later than the second business day of the independent review organization after receiving
13 the material specified in section (6) of this rule, the independent review organization shall deliver
14 to the enrollee the index of all materials that the insurer has submitted to the independent review
15 organization. The insurer shall provide to the enrollee, upon request, all relevant information
16 supplied to the independent review organization that is not confidential or privileged under state
17 or federal law concerning the case under review.
18 **(8) After receipt of the notice from the director under section (4) of this rule, the enrollee,**
19 **the insurer or a provider acting on behalf of the enrollee or at the enrollee's request may**
20 **submit additional information to the independent review organization. In accordance with**
21 **OAR 836-053-1325 (3)(b) the independent review organization must consider this**
22 **additional information if the information is related to the case and relevant to the statutory**
23 **grounds for external review contained in ORS 743.857. The independent review**
24 **organization is not required to consider this information if the information is submitted**
25 **after the seventh calendar day following the receipt of notice from the director under**
26 **section (4) of this rule, or the subsequent business day of the independent review**
27 **organization if any of the seven days is not a normal business day of the independent**
28 **review organization. Upon receiving information under this section the independent review**
29 **organization must:**
30 **(a) Forward any information provided by the insurer to the enrollee within one business**
31 **day after the independent review organization receives the information.**
32 **(b) Forward any information provided by the enrollee or a provider acting on behalf of the**
33 **enrollee or at the enrollee's request to the insurer within one business day after the**
34 **independent review organization receives the information.**
35 [(8)](9) The independent review organization shall notify the enrollee, the provider of the
36 enrollee and the insurer of any additional medical information required to conduct the review
37 after receipt of the documentation under section (7) of this rule. Not later than the fifth business
38 day of such a request, the enrollee or the provider of the enrollee shall submit the additional
39 information or an explanation of why the additional information is not being submitted to the
40 independent review organization. If the enrollee or the provider of the enrollee fails to provide
41 the additional information or the explanation of why additional information is not being
42 submitted within the timeline specified in this subsection, the assigned independent review
43 organization shall make a decision based on the information submitted by the insurer as required
44 by section (6) of this rule. Except as provided in this section, failure by the insurer to provide the
45 documents and information within the time specified in section (6) of this rule shall not delay the
46 conduct of the independent review.

1 [(9)](10) An independent review organization must provide notice to enrollees and the insurer of
2 the result and basis for the determination as provided in OAR 836-053-1325 not later than the
3 fifth day after the independent review organization makes a determination in a regular,
4 nonexpedited case.

5 Stat. Auth.: ORS 731.244, 743.858 & 743.862

6 Stats. Implemented: ORS 743.858 & 743.862

7 Hist.: ID 10-2002(Temp), f. & cert. ef. 4-5-02 thru 9-27-02; ID 19-2002, f. 9-27-02, cert. ef. 9-
8 28-02; ID 11-2011(Temp), f. & cert. ef. 7-7-11 thru 12-21-11

9
10 836-053-1342 (AMENDED)

11 Timelines and Notice for Expedited Decision-Making

12
13 (1) When an insurer expedites an enrollee's case under ORS 743.857(5), the insurer shall inform
14 the Director **of the Department of Consumer and Business Services** and the independent
15 review organization that the referral is expedited. If information on whether a referral is
16 expedited is not provided to the independent review organization, the independent review
17 organization may presume that the referral is not an expedited review, but the independent
18 review organization may request clarification from the insurer.

19 **(2) The insurer and the director must expedite external review that is required to be**
20 **expedited under ORS 743.857(5) when:**

21 **(a) An enrollee requests external review before the enrollee has exhausted all internal**
22 **appeals; or**

23 **(b) An enrollee simultaneously requests an expedited internal appeal and an expedited**
24 **external review.**

25 (3) An independent review organization shall make its decision in each expedited case within a
26 time period that is appropriate for accommodating the clinical urgency of the particular case, but
27 in any event not exceeding the maximum time period specified in ORS 743.862(3).

28 (4) In an expedited case, an independent review organization shall immediately provide notice to
29 enrollees and the insurer of the result and basis for the determination as provided in OAR 836-
30 053-1325.

31
32 Stat. Auth.: ORS 731.244, 743.858 & 743.862

33 Stats. Implemented: ORS **743.857**, 743.858 & 743.862

34 Hist.: ID 10-2002(Temp), f. & cert. ef. 4-5-02 thru 9-27-02; ID 19-2002, f. 9-27-02, cert. ef. 9-
35 28-02; ID 11-2011(Temp), f. & cert. ef. 7-7-11 thru 12-21-11

36
37 836-053-1350(AMENDED)

38 Ongoing Requirements for Independent Review Organizations

39
40 (1) An independent review organization shall file an annual statistical report with the Director **of**
41 **the Department of Consumer and Business Services**, on a form specified by the director, that
42 summarizes reviews conducted. The report shall include, but need not be limited to, volumes,
43 types of cases, compliance with timelines for expedited and nonexpedited cases, determinations,
44 number and nature of complaints and compliance with conflict of interests rules.

1 (2) An independent review organization shall submit updated information to the director if at any
2 time there is a material change in the information included in the response of the independent
3 review organization to the director's request for proposals.

4 **(3) An independent review organization shall maintain records of all materials, including materials**
5 **submitted by all parties, notifications, documents relied upon, and the independent review**
6 **organization's ultimate decision for a period of not less than three years after any review. The**
7 **independent review organization shall provide copies of any of these documents to the director at**
8 **the director's request.**

9

10 Stat. Auth.: ORS 731.244, 743.857, 743.858 & 743.862

11 Stats. Implemented: ORS 743.858 & 743.862

12 Hist.: ID 10-2002(Temp), f. & cert. ef. 4-5-02 thru 9-27-02; ID 19-2002, f. 9-27-02, cert. ef. 9-

13 28-02; ID 11-2011(Temp), f. & cert. ef. 7-7-11 thru 12-21-11