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NOTICE OF PROPOSED RULEMAKING

INCLUDING STATEMENT OF NEED & FISCAL IMPACT

FILED
08/13/2019 10:00 AM
ARCHIVES DIVISION
SECRETARY OF STATE

CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILING CAPTION: Data Sharing with Legally Liable Third Parties and Limitations on Third Parties Rejection of Claims

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 09/21/2019 5:00 PM

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

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500 Summer St NE
Salem,OR 97301

Filed By:
Brean Arnold
Rules Coordinator

HEARING(S)

Auxilary aids for persons with disabilities are available upon advance request. Notify the contact listed above.

DATE: 09/17/2019
TIME: 10:30 AM
OFFICER: Brean Arnold
ADDRESS:
500 Summer St NE
Room 137B
Salem, OR 97301
SPECIAL INSTRUCTIONS:
Send written comments to
HSD.rules@dhsoha.state.or.us

NEED FOR THE RULE(S):

The Authority needs to implement federal mandates that Oregon is to make “reasonable efforts” to determine if a third party is legally liable for some or all medical expenses paid by Medicaid for a recipient; commonly known as “third party liability” or “TPL.” By directing “insurers” to provide information regarding insured, that will help Medicaid cost avoidance and revenue collection. The Health Insurance Group (HIG) and the Medical Payment Recovery Unit (MPR) are the two units tasked with implementing the mandate. HIG collects information about insurers to make sure that insurers are billed for medical expenses before Medicaid. MPR seeks reimbursement from insurers that should have paid before Medicaid. This is to “reduce medical expenditures” for the Medicaid program. Currently, about 4 percent of Oregon Medicaid recipients are known to have private third-party coverage. In 2015 the Government Accountability Office estimated that for 2012 approximately 13.4 percent of Medicaid recipients had private third-party health coverage. They also assumed that the Affordable Care Act would increase that number. For our purposes, we will assume the national average is about 10 percent. These rules are to assist HIG and MPR in finding and recovering from third parties that are overlooked. The rule also clarifies that the Authority has assigned these duties to HIG and MPR.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

(1) Office of Payment Accuracy and Recovery Service Level Agreement found on the web at https://inside.dhsoha.state.or.us/images/stories/OPAR_quicklinks/2017-19_OPAR_Office_Service_Level_Agreement_1.1.doc;
(2) Shared Services – Memorandum of Understanding at https://inside.dhsoha.state.or.us/images/stories/shared_governance/11-0001_IGA_Shared_Services_2.pdf;
(3) GAO Additional Federal Action Needed to Improve Third-Party Liability Efforts, January 2015 at https://www.gao.gov/assets/670/668134.pdf

FISCAL AND ECONOMIC IMPACT:

Currently the HIG and MPR programs in the last biennium generated $14,813,813.98 in revenue and $160,980,180.00 in cost avoidance. Assuming the rules will allow Oregon to achieve the national average, we can project a 6 percent increase of $888,828.84 in revenue and $9,658,810.80 cost avoidance for a two-year period.

COST OF COMPLIANCE:

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

1) Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)): Adopting this rule will reduce Authority medical expenditures by increasing cost avoidance and revenue collections from liable third parties. This may have similar effects on CCOs and Prepaid Managed Health Care Organizations. The Authority will have an unknown cost implementing electronic data exchanges and data matches. The new rule will have no fiscal impact on other state agencies, units of local government or the public. It will have a fiscal impact on insurance industry because insurers of Medicaid recipients will have to pay out on more claims and reimburse the Authority on more claims. That is estimated to be a 6 percent increase totaling $10,547,639.64 for a two-year period. Insurers may have to add additional staff to handle the increased number of claims and implement electronic data exchanges. The agency does not have sufficient information about insurer operations to guess the fiscal impact to implement the electronic data exchanges.
2a) Estimate the number of small businesses and types of business and industries with small businesses subject to the rule: The agency asked the Insurance Division of the Department of Consumer and Business Services for assistance in determining how many small businesses would be affected, but they lack data that would allow the agency to extrapolate how many businesses or the types of businesses that would be affected. It is reasonable to assume that any small business could be affected by this, particularly if its medical insurance is self-insured.
2b) Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services: A business would have to retain records for at least three years of all individuals' coverage by their group health insurance, the type and terms of coverage, the name, date of birth, and Social Security number.
2c) Equipment, supplies, labor and increased administration required for compliance: The agency lacks information or knowledge of small business operations from which to extrapolate this information.

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

Small businesses were not consulted.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

ADOPT: 410-120-1285

RULE SUMMARY: The Authority needs to implement federal mandates that Oregon is to make "reasonable efforts" to

determine if a third party is legally liable for some or all medical expenses paid by Medicaid for a recipient; commonly known as “third party liability” or “TPL.” By directing “insurers” to provide information regarding insured, that will help Medicaid cost avoidance and revenue collection.

CHANGES TO RULE:

410-120-1285
Recoupment and Data Sharing with Third-Party Insurers
(1) The Oregon Health Authority (Authority) delegates to the Department of Human Services (Department), Office of Payment Accuracy and Recovery (OPAR) authority to administer Third-Party Liability programs required by federal law to reduce medical expenditures. This includes the following programs:¶
(a) The Data Match Unit;¶
(b) The Health Insurance Group;¶
(c) The Medical Provider Recovery Unit; and¶
(d) The Personal Injury Liens Unit.¶
(2) For this rule, an "insurer" means an employee benefit plan, self-insured plan, managed care organization or group health plan, a third-party administrator, fiscal intermediary or pharmacy benefit manager of the plan or organization, or other party that is by statute, contract, or agreement legally responsible for payment of a claim for a health care item or service.¶
(3) "OPAR" means the Office of Payment Accuracy and Recovery, Department of Human Services, and subunits.¶
(4) For this rule "subscriber" means an individual who is eligible for coverage on their behalf and not because of dependent status.¶
(5) An insurer shall provide to OPAR, a CCO, or a Managed Care Organization, upon request, within 30 calendar days, the following information:¶
(a) The period during which a recipient, a spouse, or dependents are covered by the insurer;¶
(b) The nature of coverage that is provided by the insurer; for example, medical, prescription drug, dental, vision, motor vehicle personal injury protection, or workers compensation;¶
(c) The name, claim submission address, and identifying numbers of the plan; for example, group and policy numbers; ¶
(d) The name of the subscriber, if any, and the date of birth and social security number;¶
(e) The amount of any copay, coinsurance, or deductible required by the insurer.¶
(6) An insurer may not deny a claim submitted by OPAR, a managed care organization, or a CCO, based on the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point of sale that is the basis of the claim if:¶
(a) The claim is submitted within the three-year period beginning on the date on which the health care item or service was furnished; and¶
(b) Any action to enforce the claim is commenced within six years of submission of the claim.¶
(7) An insurer must process a claim submitted by the Authority, a managed care organization, or a CCO within 30 calendar days. If an insurer denies a claim or does not pay the claim in full, the insurer shall provide a detailed explanation for its action, including citation to applicable contractual or statutory authority for the action. If the insurer cites a contractual provision, the insurer shall provide a copy of the applicable contractual provision on request.¶
(8) An insurer shall provide OPAR an electronic file of all insured or subscribed individuals residing in Oregon to assist OPAR to do a data match with recipient records to determine if any Medicaid recipient has coverage through the insurer. The electronic file shall be delivered to OPAR every 30 days, unless otherwise agreed. The Authority may enter into a trading partner agreement with the insurer to permit the exchange of information via "ASC X 12N 270/271 Health Benefit Inquiry and Response" transactions or other HIPAA compliant secure transaction methods in the event 270/271 transactions are not available. The insurer shall include the following information in the electronic file:¶
(a) The period during which a subscriber or insured, the spouse, or dependents are covered by the plan;¶

(b) The nature of coverage that is provided by the plan; for example, medical, prescription, dental, vision, or automotive personal injury protection, and workers compensation;¶
(c) The name, claim submission address, and identifying numbers of the plan; for example, group and policy numbers; ¶
(d) The name of the subscriber, if any, and date of birth and social security number;¶
(e) The amount of any copay, coinsurance, or deductible required by the insurer.¶
(9) An insurer may not charge a fee for sharing data with the Authority, OPAR, a managed care organization, or CCO or for processing claims submitted by OPAR, a managed care organization, or a CCO.¶
(10) In the event a claim submitted to an insurer by OPAR, a managed care organization, or a CCO is paid all or in part to a third party, the insurer shall within 14 calendar days give the name and address of the payee, the check number, date and amount of the check or electronic payment, and a copy of the check or electronic payment to the claimant on request.
Statutory/Other Authority: ORS 413.042, 413.085, 414.685, 42 USC 1396a(a)(25) & (45), 42 USC 1396k, 42 CFR 433.135 to 433.139, 42 CFR 433.145 to 433.146, Oregon Medicaid State Plan Attachment 4.22-A(3) & (7)
Statutes/Other Implemented: ORS 414.685, 659.830, 743B.470