Oregon
Theodore R. Kulongoski, Governor

**Department of Consumer and Business Services**
Insurance Division
350 Winter St. NE, Room 440
PO Box 14480
Salem, OR 97301-0405
(503) 947-7980
FAX (503) 378-4351
TTY (503) 947-7280
www.oregoninsurance.org

# OREGON INSURANCE DIVISION BULLETIN INS 2003-7

**DATE:** February 13, 2004

**TO:** All Casualty Insurers that provide Motor Vehicle Liability Insurance

**SUBJECT:** Revision to Bulletin INS 2003-7 Originally Issued on November 10, 2003
Change in PIP Benefits under HB 3668 (ch. 813 Oregon Laws 2003)

## Introduction

This bulletin supersedes Insurance Division Bulletin INS 2003-7, which was issued on November 10, 2003. The earlier bulletin dealt with the one issue of the limitations in section 4 of HB 3668 on the charges by a provider to a person who receives personal injury protection benefits. Since then, additional questions from insurers, providers and other stakeholders have caused the Insurance Administrator to reexamine the legislative history of the bill and the issues relating to its implementation. The answer to the issue in the earlier bulletin is unchanged. The purpose of this bulletin is to address the additional issues.

House Bill 3668, passed in the 2003 session of the Oregon Legislative Assembly, makes changes in the provisions of the Insurance Code dealing with personal injury protection benefits required to be provided in motor vehicle liability insurance policies issued in Oregon.

This bulletin summarizes key provisions of HB 3668 and explains the Insurance Division's interpretation of the legislation.

HB 3668 is available on the Insurance Division website at www.oregoninsurance.org. Then click on "Laws, Rules and Bulletins." Click on *2003 Legislature*, then *Casualty Insurance*.

## Summary of Legislation

HB 3668 increases payments under PIP benefits for reasonable and necessary expenses of medical, hospital, dental, surgical, ambulance and prosthetic services from $10,000 to $15,000. Section 4 of the legislation prohibits a provider from charging a person who receives PIP benefits or that person's insurer an amount that exceeds the amount the provider charges the general public or an amount that exceeds the fee schedules for medical services published pursuant to statute for expenses of medical and other services provided under the Oregon workers' compensation laws.

## Discussion

1. **Limitation on charges by providers**. Questions have arisen as to the meaning of the limitations in section 4 of HB 3668 on charges by a provider. The Insurance Division interprets section 4 to mean that a provider may not charge a fee that exceeds the amount that the provider charges the general public or the amount in the applicable workers' compensation fee schedule for medical and other services, whichever amount is less. This answer is consistent with the determination of costs for workers' compensation purposes in ORS 656.248.

2. **Scope of application of fee schedules adopted under workers' compensation statute.** It has been asked whether the rules of the Workers' Compensation Division that establish limitations on services and benefits available for workers' compensation claims are included within the scope of the fee schedules established pursuant to ORS 656.248. The wording of section 4 of the bill refers specifically to the fee schedules for medical services published pursuant to ORS 656.248 and the legislative history indicate the narrower intent and reading. The reference to the fee schedules means only the fee schedules—only the specific fees established by the schedules—and not the limitations on services and benefits. For example, the limitation on chiropractic services to 12 sessions and 30 days in OAR 436-010-0005(2)(c) does not apply to the determination of or payment for PIP benefits. In contrast, the hospital charge to cost ratios in OAR 436-009-0020(1) and (2) (and updated by WCD bulletin), for example, do apply because the ratios establish the amounts that hospitals will receive for workers' compensation services. Similarly, the pharmacy fee schedule applies because it establishes amounts to be paid for medical and other services.

3. **Applicability of the "reasonable and necessary" standard in ORS 742.524 to section 4, HB 3668**. ORS 742.524 states that personal injury protection benefits consist of "all reasonable and necessary expenses of medical, hospital, dental, surgical, ambulance and prosthetic services incurred within one year after the date of the person's injury, but not more than $15,000 in the aggregate for all such expenses of the person." It has been asked whether the "reasonable and necessary" standard is separate and distinct from the lesser-than standard established in section 4, HB 3668. Although our answer is not free from doubt, the correct answer appears to be that the "reasonable and necessary" standard is not a separate standard with respect to the determination of costs, but instead is defined for the purpose of costs by the lesser-than standard in section 4. This reading is consistent with the determination of costs for workers' compensation purposes in ORS 656.248. The "reasonable and necessary" standard continues to apply, however, with respect to the need for and appropriateness of treatment.

4. **Determination of a fee when the service is not included in the fee schedules for workers' compensation.** The amount that is payable in such a case is the amount the provider charges the general public, as provided in section 4. For example, the workers' compensation fee schedules do not include fees for dental or ambulance services. The applicable charges for those services will be the amounts charged the general public by the provider. This answer is consistent with the determination of costs for workers' compensation purposes in ORS 656.248.

5. **Date on which the new standards apply for payment of provider services in section 4.** As stated in section 5 of HB 3668, the new standards apply with respect to motor vehicle liability policies issued or renewed on or after the effective date of HB 3668, which was January 1, 2004. Insurers may therefore apply the lesser-than standard in section 4 to provider expenses incurred on or after the renewal date of an existing policy, but not before. For claims that occur prior to renewal, insurers should continue paying benefits according to contract terms in force on the date of loss.

6. **Date on which the increase in PIP benefits to $15,000 applies.** An insurer is required to apply the increase on and after the date of issuance or renewal of a policy. An insurer may voluntarily adopt the increase midterm as long as the insurer does not increase premiums midterm for the additional coverage.

7. **Provider concerns about amounts paid for PIP benefits for a policy that is issued or renewed on or after January 1, 2004.** The provider must deal with the insurer to resolve the concerns. The provider may not require additional payment from the policyholder.

This bulletin is dated the 13th day of February 2004, at Salem, Oregon.

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Joel Ario**,** Insurance Administrator