



# Oregon

Theodore R. Kulongoski, Governor

## Department of Consumer and Business Services

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### OREGON INSURANCE DIVISION BULLETIN INS 2007-1

DATE: February 15, 2007

TO: All Insurers Providing Benefits Under a Health Benefit Plan

RE: Reporting Requirements for Prompt Payment of Claims Under Requirements of ORS 743.866

The purpose of this bulletin is to provide guidance to insurers of health benefit plans to enable them to properly comply with OAR 836-080-0085, the reporting of Prompt Payment data. We have reviewed the 2005 prompt payment data submitted by insurers and have noted some matters of noncompliance with the reporting rule. We call your attention to the following requirements of the rule in which the noncompliance has arisen.

1. An insurer must submit its prompt payment data to the Director **not later than** March 1 of each year, pursuant to OAR 836-080-0085(2).
2. An insurer must include in the prompt payment data only those claims that the insurer finally disposed of later than the 30<sup>th</sup> day after the date on which the insurer received the claim, pursuant to OAR 836-080-0085(2)(b).
3. When an insurer reports prompt payment claim data with respect to requests for additional information, the insurer must report only that date on which the insurer **first** requested additional information, pursuant to OAR 836-080-0085(4)(b). The Division has received prompt payment claim data that reports each time additional information was requested or received on a given claim. That is incorrect. Instead, in order to accurately measure the responsiveness of an insurer's claim processing procedures, please report **only** that date on which the insurer **first** requested additional information on a claim.
4. When an insurer reports data with respect to receipt of additional information, the insurer must report only that date on which the insurer last received the additional information that allowed the claim to be disposed, pursuant to OAR 836-080-0085(4)(c).
5. An insurer must submit a report of its data not **later than** the 60<sup>th</sup> day after the date on which the insurer receives the selection of sample files from the Director, as required by OAR 836-080-0085(5).
6. The prompt pay data requirement applies only to claims that are made under a health benefit plan and submitted by a provider on behalf of an enrollee. Insurers must not submit claims made under coverage other than health benefit plans, such as dental only coverage, Medicare supplement insurance and student accident and health insurance

policies. Please note the definition of “health benefit plan” in ORS 743.730(18) for your guidance.

7. An insurer must provide claim data for Oregon providers only. Please do not provide claim data for providers from other states. “Provider” is defined in ORS 743.801(13) as a person licensed, certified or otherwise permitted by laws of this state (Oregon) to administer medical or mental health services in the ordinary course of business or practice of a profession.
8. An insurer must not include credits or adjustments in its claim data. Please see the instructions for the Report of Prompt Payment Data Form (#440-3431).

If you have questions regarding Prompt Pay requirements, please contact:

Douglas Beck, Market Analyst, 503-947-7204, [Douglas.beck@state.or.us](mailto:Douglas.beck@state.or.us)

OR

Michael Lyndon, Market Surveillance Manager, 503-947-7219, [Michael.B.Lydon@state.or.us](mailto:Michael.B.Lydon@state.or.us)

This bulletin takes effect immediately.

This bulletin is dated the 15th day of February 2007 at Salem, Oregon.

(Signed)

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Joel Ario, Oregon Insurance Administrator