

**Oregon Department of Consumer and Business Services  
Division of Financial Regulation, Bulletin No. DFR 2020-15**

TO: All Entities Transacting Health Insurance in Oregon

DATE: August 20, 2020

RE: Guidance for Health Benefit Plan External Review Requests

**Purpose**

This bulletin provides operational guidance and clarification on the external review process for individual and group health benefit plans in the state of Oregon, and clarifies the Division of Financial Regulation's (division) expectations of health insurers.

**Authority**

- ORS 731.244
- ORS 731.296
- ORS 742.005
- ORS 743B.250 – 743B.256
- OAR 836-010-0011
- OAR 836-053-1340 – 836-053-1342

**Background**

The requirement for health insurers to provide enrollees with the opportunity for external review of adverse benefit determinations, such as denying coverage of specific health care items or services, as established by ORS 743B.250 through 743B.258, is a bedrock consumer protection.

In recent years, the division has taken a series of steps to improve health insurance carrier compliance with the Oregon statutes and administrative rules relating to external review requirements. As part of this process, the division determined that additional clarification regarding health insurance carriers' obligations and options under these requirements could improve the efficiency and fairness of the external review process for all parties.

To provide this clarification, the division supplied Oregon health insurance carriers with informal guidance on multiple occasions, and encouraged carriers to update internal policies, procedures and processes, and review all communications to consumers for compliance with the applicable external review statutes and rules. This bulletin formalizes that guidance.

The division plays a role in the external review process by assigning Independent Review Organizations (IRO) to respond to external review requests, providing required notices to health plans and health plan enrollees, overseeing compliance with the process, and occasionally

receiving requests for external review directly from enrollees. This bulletin reiterates the division's role and obligations under the Oregon Insurance Code.

### **Guidance for insurers and other regulated entities**

The timeframes and deadlines for the handling of external review requests specified by ORS 743B.250, ORS 743B.252, OAR 836-053-1340, and OAR 836-053-1342 are binding, and regulated entities must strictly adhere to them.

Key timeline considerations specified in statute and rule for external review requests that are not expedited<sup>1</sup> include the following:

- 1) Insurer must notify the division of external review request: 2 business days following receipt of request from enrollee. *OAR 836-053-1340(1)*<sup>2</sup>
- 2) The division must select IRO and notify insurer: 1 business day following receipt of notice from insurer. *OAR 836-053-1340(3)*
- 3) The division must notify enrollee of IRO selection: 2 business days following receipt of notice from insurer. *OAR 836-053-1340(4)*<sup>3</sup>
- 4) Insurer must provide IRO with specified information regarding the adverse benefit determination, as well as a signed waiver granting access to the enrollee's medical records: 5 business days following insurer receipt of notice from the division. *ORS 743B.252(3) and 743B.255, OAR 836-053-1340(6)*
- 5) IRO must issue decision: 30 calendar days after the enrollee applies to the insurer for a review or the director orders a review. *ORS 743B.256(4)*
- 6) IRO must notify enrollee and insurer of decision: 5 calendar days after decision is issued. *OAR 836-053-1340(10)*
- 7) End of external review eligibility period: 180 calendar days following an enrollee's receipt of the final written decision of an adverse benefit determination. *ORS 743B.255(1)*

Notifying the division of external review requests is a critical step in the oversight process. The division expects insurers to comply with the requirement to notify the division regardless of whether the enrollee (or the enrollee's health care provider) has provided all of the documents and information that the insurer is required to submit to the IRO under OAR 836-053-1340(6), including the required waiver granting the release of medical records.

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<sup>1</sup> Expedited requests are subject to the expedited timelines specified by ORS 743B.256 and OAR 836-053-1342.

<sup>2</sup> If the director receives a request for external review directly from a health plan enrollee, the division must notify the insurer *and* assign an IRO no later than the next business day. *OAR 836-053-1340(1)*

<sup>3</sup> An enrollee may present evidence of a conflict of interest of the selected IRO within 3 business days following the enrollee's receipt of the notification specified in 3). If the director determines that a conflict of interest exists, a new IRO will be selected, and notices will be sent to the enrollee and the insurer. In such instances, the 5 business days timeline specified in 4) will start over with the notification of the new IRO selection. *OAR 836-053-1340(5)*

Once an insurer has notified the division of receipt of an external review request, it is the division's responsibility to select an IRO for the request and notify the insurer of the IRO selection within one business day.

Under OAR 836-053-1305(2), any action taken by a health benefit plan enrollee under Oregon's external review statutes may be taken on the enrollee's behalf by a representative of the enrollee. If authorized to represent the enrollee, a health care provider or other party may serve in this capacity and represent the enrollee throughout the external review process. However, health care providers and other parties do not have the right to external review of adverse benefit determinations unless they have the consent of the enrollee that is subject to the adverse benefit determination.

If an insurer receives a request for external review of an adverse benefit determination from an enrollee's health care provider or other party, the insurer may request reasonable documentation of the enrollee's consent to be represented.

In instances where this documentation is not provided to the insurer along with the initial request for external review, the division expects insurers to act in good faith, exercise due diligence and make all reasonable efforts to communicate the need for this documentation from the enrollee through all established communication channels. The division also expects that the insurer notify the division of receipt of the external review request in these instances. However, for the purposes of the external review timeline detailed above, the insurer will not be considered to have received the request until proof of consent or a new external request is received from the enrollee, at which point the insurer must again notify the division, and the division will assign an IRO.

Following IRO selection, OAR 836-053-1340(6)(d) requires insurers to supply the IRO with a waiver signed by the enrollee requesting external review within 5 business days following the division's notice that an IRO has been assigned. The division expects insurers to act in good faith to obtain a signed waiver to supply to the IRO within the required timeframe, and to exercise due diligence and make all reasonable efforts to obtain this document from the enrollee through all established communication channels.

To ensure transparency and an equitable and uniform approach to this issue, the division instructs insurers to develop and follow a set of written policies and procedures to ensure timely receipt of a signed waiver from an enrollee to enable compliance with the required timelines for the external review process. This set of policies and procedures must be specified in policy forms subject to review by the division, including both a consumer-facing description of the process to get a signed waiver and a document detailing the carrier's internal policies and procedures in this area. Additional guidance will be provided regarding the division's expectations for the form filing process. Form filings lacking sufficient documentation of an insurer's policies and procedures in this area, or providing for insufficient due diligence in obtaining waivers from enrollees, may be subject to disapproval under ORS 742.005.

An insurer's written policy in this area may meet these requirements in a variety of ways. Enrollees may be asked to sign a single form allowing the insurer to release information to any IRO on contract with the division, or a unique form for each IRO, or a unique form for each request for external review, and these forms may be offered to enrollees at any time.

If an insurer has exercised all due diligence and remains unable to forward a signed waiver to the IRO within the five business days, the external review request is deemed ineligible under ORS 743B.255 and the timeline for IRO review terminates.

However, if the enrollee supplies the signed waiver after the end of the five business days but before the end of the 180-day eligibility period for external review, the division expects the insurer to accept the submitted document and proceed with the external review process.

For the purposes of any internal recordkeeping or communication with the enrollee about the external review process that is not specifically required by law or rule, insurers may treat a late waiver submission as part of the original request for external review. However, for the purposes of the external review timeline, insurers must treat a late submission of a signed waiver as the initiation of a new external review request. This includes providing the required notice to the division within two business days of the late submission in the same fashion as a new external review request, and supplying the same IRO with the information that was originally required by OAR 836-053-1340(6) within five business days of DFR's notification of IRO selection. In these instances, the 30 days for IRO review will begin on the date that the signed waiver is received by the insurer. Barring unusual circumstances, the IRO originally assigned to the external review case will continue in this role. If it is necessary in a particular instance to assign a new IRO, the division will make this assignment within one business day after receiving the required notice from the insurer as required by OAR 836-053-1340(5).

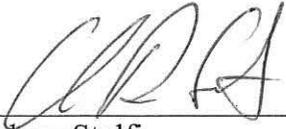
An insurer may assist an enrollee in completing an external review application by entering the information provided by the enrollee after the enrollee has asked for assistance. If an enrollee does not ask for assistance, an insurer is not permitted to prefill or complete application paperwork on behalf of an enrollee.

Some insurers may seek to implement changes to existing systems for receiving and processing external review requests and enrollee waiver documents in response to this guidance. The division may exercise discretion on a case-by-case basis to make reasonable accommodations for insurers to achieve compliance with this guidance, for a limited time, provided that insurers can demonstrate a good faith effort to comply, and that enrollee access to external review is not adversely affected. The division expects insurers to have implemented any operational changes necessary in response to this bulletin by October 1, 2020. Insurers found to be out of compliance on or after that date may be subject to enforcement action.

Any changes to policy forms necessary to achieve compliance with this bulletin must be made for health benefit plans issued or renewed on or after January 1, 2021.

Nothing in this bulletin shall be construed to limit the division's authority under the Oregon Insurance Code or its ability to continue enforcing the laws of the State of Oregon.

This bulletin takes effect immediately. It remains in effect until superseded by a further bulletin of the Division of Financial Regulation.



Andrew Stolfi  
Director and Insurance Commissioner  
Department of Consumer and Business Services

8/20/2020

Date