Senate Bill 385

Sponsored by Senator BATES (Presession filed.)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.**

Requires Department of Consumer and Business Services, considering recommendation of Oregon Health Authority and stakeholder group, to prescribe standards and single form to be used for provider to request prior authorization for coverage of prescription drugs. Requires insurer or other payer to approve or deny request within 48 hours or request is deemed approved.

A BILL FOR AN ACT

Relating to requests for prior authorization for coverage of prescription drugs; amending ORS 743.061, 743.062, 743.801, 743.806 and 743.807.

Be It Enacted by the People of the State of Oregon:

SECTION 1. ORS 743.061 is amended to read:

743.061. (1) The Department of Consumer and Business Services may adopt by rule uniform standards applicable to persons listed in subsection [*(2)*] **(3)** of this section for health care financial and administrative transactions, including uniform standards **and forms** for:

(a) Eligibility inquiry and response;

(b) Claim submission;

(c) Payment remittance advice;

(d) Claims payment or electronic funds transfer;

(e) Claims status inquiry and response;

(f) Claims attachments;

[*(g) Prior authorization;*]

[*(h)*] **(g)** Provider credentialing; or

[*(i)*] **(h)** Health care financial and administrative transactions identified by the stakeholder work group described in ORS 743.062.

(2) The department shall adopt by rule uniform standards applicable to persons listed in subsection (3) of this section for prior authorization requests for coverage of prescription drugs. The standards must include a single form to be used by any provider making a request for prior authorization of a prescription drug. The form may not exceed two pages in length and must be electronically available and transmissible. A person listed in subsection (3) of this section must approve or deny a request for prior authorization submitted using the form described in this subsection no later than 48 hours after receipt of the request. If the person fails to timely approve or deny the request, the request shall be deemed to have been approved.

[*(2)*] **(3)** Any uniform standards **and forms** adopted under [*subsection*] **subsections** (1) **and (2)** of this section apply to:

(a) Health insurers.

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

(b) Prepaid managed care health services organizations as defined in ORS 414.736.

(c) Third party administrators.

(d) Any person or public body that either individually or jointly establishes a self-insurance plan, program or contract, including but not limited to persons and public bodies that are otherwise exempt from the Insurance Code under ORS 731.036.

(e) Health care clearinghouses or other entities that process or facilitate the processing of health care financial and administrative transactions from a nonstandard format to a standard format.

(f) Any other person identified by the department that processes health care financial and administrative transactions between a health care provider and an entity described in this subsection.

[*(3)*] **(4)** In developing or updating any uniform standards adopted under subsection (1) **or (2)** of this section, the department shall consider recommendations from the Oregon Health Authority under ORS 743.062.

SECTION 2. ORS 743.062 is amended to read:

743.062. (1) The Oregon Health Authority shall convene a stakeholder work group to recommend uniform standards **and forms** for health care financial and administrative transactions, including, to the extent allowed by law, standards applicable to commercial health insurance plans, self-funded plans and state governmental health plans and programs.

(2) The authority shall report uniform standards **and forms** recommended under subsection (1) of this section to the Department of Consumer and Business Services for consideration in the adoption of uniform standards **and forms** by the department under ORS 743.061.

(3) The stakeholder work group, in recommending uniform standards **and forms** under subsection (1) of this section, shall consider or incorporate any applicable national standards for administrative simplification and timelines for implementation of national standards for administrative simplification that are established pursuant to federal law.

SECTION 3. ORS 743.801, as amended by section 5, chapter 24, Oregon Laws 2012, is amended to read:

743.801. As used in this section and ORS **743.061,** 743.803, 743.804, 743.806, 743.807, 743.808, 743.811, 743.814, 743.817, 743.819, 743.821, 743.823, 743.827, 743.829, 743.831, 743.834, 743.837, 743.839, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.894, 743.911, 743.912, 743.913, 743.917 and 743.918:

(1) "Adverse benefit determination" means an insurer's denial, reduction or termination of a health care item or service, or an insurer's failure or refusal to provide or to make a payment in whole or in part for a health care item or service, that is based on the insurer's:

(a) Denial of eligibility for or termination of enrollment in a health benefit plan;

(b) Rescission or cancellation of a policy or certificate;

(c) Imposition of a preexisting condition exclusion as defined in ORS 743.730, source-of-injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or services;

(d) Determination that a health care item or service is experimental, investigational or not medically necessary, effective or appropriate; or

(e) Determination that a course or plan of treatment that an enrollee is undergoing is an active course of treatment for purposes of continuity of care under ORS 743.854.

(2) "Authorized representative" means an individual who by law or by the consent of a person may act on behalf of the person.

(3) "Enrollee" has the meaning given that term in ORS 743.730.

(4) "Grievance" means:

(a) A communication from an enrollee or an authorized representative of an enrollee expressing dissatisfaction with an adverse benefit determination, without specifically declining any right to appeal or review, that is:

(A) In writing, for an internal appeal or an external review; or

(B) In writing or orally, for an expedited response described in ORS 743.804 (2)(d) or an expedited external review; or

(b) A written complaint submitted by an enrollee or an authorized representative of an enrollee regarding the:

(A) Availability, delivery or quality of a health care service;

(B) Claims payment, handling or reimbursement for health care services and, unless the enrollee has not submitted a request for an internal appeal, the complaint is not disputing an adverse benefit determination; or

(C) Matters pertaining to the contractual relationship between an enrollee and an insurer.

(5) "Health benefit plan" has the meaning given that term in ORS 743.730.

(6) "Independent practice association" means a corporation wholly owned by providers, or whose membership consists entirely of providers, formed for the sole purpose of contracting with insurers for the provision of health care services to enrollees, or with employers for the provision of health care services to employees, or with a group, as described in ORS 743.522, to provide health care services to group members.

(7) "Insurer" includes a health care service contractor as defined in ORS 750.005.

(8) "Internal appeal" means a review by an insurer of an adverse benefit determination made by the insurer.

(9) "Managed health insurance" means any health benefit plan that:

(a) Requires an enrollee to use a specified network or networks of providers managed, owned, under contract with or employed by the insurer in order to receive benefits under the plan, except for emergency or other specified limited service; or

(b) In addition to the requirements of paragraph (a) of this subsection, offers a point-of-service provision that allows an enrollee to use providers outside of the specified network or networks at the option of the enrollee and receive a reduced level of benefits.

(10) "Medical services contract" means a contract between an insurer and an independent practice association, between an insurer and a provider, between an independent practice association and a provider or organization of providers, between medical or mental health clinics, and between a medical or mental health clinic and a provider to provide medical or mental health services. "Medical services contract" does not include a contract of employment or a contract creating legal entities and ownership thereof that are authorized under ORS chapter 58, 60 or 70, or other similar professional organizations permitted by statute.

(11)(a) "Preferred provider organization insurance" means any health benefit plan that:

(A) Specifies a preferred network of providers managed, owned or under contract with or employed by an insurer;

(B) Does not require an enrollee to use the preferred network of providers in order to receive benefits under the plan; and

(C) Creates financial incentives for an enrollee to use the preferred network of providers by providing an increased level of benefits.

(b) "Preferred provider organization insurance" does not mean a health benefit plan that has as its sole financial incentive a hold harmless provision under which providers in the preferred network agree to accept as payment in full the maximum allowable amounts that are specified in the medical services contracts.

(12) "Prior authorization" means a determination by an insurer prior to provision of services that the insurer will provide reimbursement for the services. "Prior authorization" does not include referral approval for evaluation and management services between providers.

(13) "Provider" means a person licensed, certified or otherwise authorized or permitted by laws of this state to administer medical or mental health services in the ordinary course of business or practice of a profession.

(14) "Utilization review" means a set of formal techniques used by an insurer or delegated by the insurer designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services, procedures or settings.

SECTION 4. ORS 743.806, as amended by section 7, chapter 24, Oregon Laws 2012, is amended to read:

743.806. All utilization review performed pursuant to a medical services contract to which an insurer is not a party shall comply with the following:

(1) The criteria used in the review process and the method of development of the criteria shall be made available for review to a party to such medical services contract upon request.

(2) A doctor of medicine or osteopathy licensed under ORS chapter 677 shall be responsible for all final recommendations regarding the necessity or appropriateness of services or the site at which the services are provided and shall consult as appropriate with medical and mental health specialists in making such recommendations.

(3) Any patient or provider who has had a request for treatment or payment for services denied as not medically necessary or as experimental shall be provided an opportunity for a timely appeal before an appropriate medical consultant or peer review committee.

(4) **Except as provided in ORS 743.061 (2),** a provider request for prior authorization of nonemergency service must be answered within two business days, and qualified health care personnel must be available for same-day telephone responses to inquiries concerning certification of continued length of stay.

SECTION 5. ORS 743.807 is amended to read:

743.807. (1) All insurers offering a health benefit plan in this state that provide utilization review or have utilization review provided on their behalf shall file an annual summary with the Department of Consumer and Business Services that describes all utilization review policies, including delegated utilization review functions, and documents the insurer's procedures for monitoring of utilization review activities.

(2) All utilization review activities conducted pursuant to subsection (1) of this section shall comply with the following:

(a) The criteria used in the utilization review process and the method of development of the criteria shall be made available for review to contracting providers upon request.

(b) A doctor of medicine or osteopathy licensed under ORS chapter 677 shall be responsible for all final recommendations regarding the necessity or appropriateness of services or the site at which the services are provided and shall consult as appropriate with medical and mental health specialists in making such recommendations.

(c) Any provider who has had a request for treatment or payment for services denied as not

medically necessary or as experimental shall be provided an opportunity for a timely appeal before an appropriate medical consultant or peer review committee.

(d) **Except as provided in ORS 743.061 (2),** a provider request for prior authorization of nonemergency service must be answered within two business days, and qualified health care personnel must be available for same-day telephone responses to inquiries concerning certification of continued length of stay.
