SB 249 -1 STAFF MEASURE SUMMARY

Senate Committee On Health Care

Prepared By: Brian Nieubuurt, LPRO Analyst
Meeting Dates: 2/6, 2/18

WHAT THE MEASURE DOES:

Prohibits health insurer form performing any unfair claim settlement practices when making a determination on a health care provider or enrollee's request for prior authorization of a health care item or service. Specifies actions that constitute unfair claim settlement practice. Prohibits health insurer from engaging in general business practice of refusing, without just cause, to approve requests for prior authorization of items or services covered by policy or certificate. Specifies evidence that demonstrates refusal to approve without just cause. Clarifies response time requirements for insurer to response to requests prior authorization. Clarifies definition of "adverse benefit determination" to include denial, in whole or in part, of a request for prior authorization.

REVENUE: May have revenue impact, but no statement yet issued.
FISCAL: May have fiscal impact, but no statement yet issued.

ISSUES DISCUSSED:

- Purpose and use of prior authorization practices
- Frequency and type of grievances received by DCBS
- Workgroup process

EFFECT OF AMENDMENT:

-1 Clarifies circumstances constituting unfair claim settlement practice based on failure to act promptly, equitably and in good faith. Clarifies prohibition against a pattern of refusing, without just cause, requests for prior authorization.

BACKGROUND:

Through its Division of Financial Regulation, the Department of Consumer and Business Services (DCBS) is the state's primary regulator of all types of insurance companies, including health insurance companies. In 2015, the division regulated health insurers covering approximately 1 million Oregonians in the individual, small group, large group, and associations and trusts markets. An estimated 710,000 Oregonians were covered by self-insured employers, which are regulated by the federal government under the 1974 Employee Retirement Income Security Act (ERISA). Health insurance policies and certificates may include prior authorization requirements that require approval of certain items or services before the insured can receive them.

Senate Bill 249 prohibits prior authorization practices defined by the bill as an unfair claim settlement practice or pattern of refusal requests.