PRELIMINARY

SB 249 A STAFF MEASURE SUMMARY

House Committee On Health Care

Prepared By: Oliver Droppers, LPRO Analyst
Meeting Dates: 5/9, 5/14

WHAT THE MEASURE DOES:

Prohibits health insurer from 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 practices. Prohibits health insurer from engaging in pattern or 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 time requirements for insurer to respond to prior authorization requests. Clarifies definition of "adverse benefit determination" to include denial, in whole or in part, of a request for prior authorization.

FISCAL: No impact.

REVENUE: No impact.

ISSUES DISCUSSED:

EFFECT OF AMENDMENT:

No amendment.

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-A clarifies expectations and timelines for health insurer reviews of prior authorization requests.

1st Chamber vote (Senate): Ayes, 29; 1 excused.