

**A-Engrossed**  
**Senate Bill 139**

Ordered by the Senate April 15  
Including Senate Amendments dated April 15

Printed pursuant to Senate Interim Rule 213.28 by order of the President of the Senate in conformance with pre-session filing rules, indicating neither advocacy nor opposition on the part of the President (at the request of Senate Interim Committee on Health Care)

**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.

*[Imposes restrictions and reporting requirements for utilization management of health services by commercial insurers, coordinated care organizations and state medical assistance program.]* **Creates new requirements applicable to prior authorization, step therapy and other utilization review policies and procedures on insurers offering health benefit plans and health insurance, medical services contracts, multiple employer welfare arrangements, health care service contracts and pharmacy benefit managers. Extends from 30 to 90 days period during which insurer's approval of prior authorization is binding on insurer.**

**Authorizes provider to act on behalf of enrollee, upon request of enrollee, with respect to internal appeals and external reviews of adverse benefit determination concerning utilization review.**

**Requires insurers offering health benefit plans to report specified information to Department of Consumer and Business Services regarding requests for prior authorization.**

**A BILL FOR AN ACT**

1  
2 Relating to managing the utilization of health services; creating new provisions; and amending ORS  
3 743.035, 743B.001, 743B.250, 743B.256, 743B.420, 743B.423 and 743B.602.

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

5 **SECTION 1. Sections 2 to 4 of this 2019 Act are added to and made a part of the Insur-**  
6 **ance Code.**

7 **SECTION 2. An insurer offering a policy or certificate of health insurance in this state**  
8 **that covers medical services, prescription drugs or dental care shall:**

9 (1) **Approve a request for prior authorization of a course of treatment with a prescription**  
10 **drug for a consecutive 12-month period if:**

11 (a) **Continued use of the prescription drug for the 12-month period is based on clinical**  
12 **evidence; and**

13 (b) **The patient continues to be insured during the 12-month period.**

14 (2) **Establish prior authorization or step therapy protocols using clinical review criteria**  
15 **that are evidence-based and continuously updated based on new evidence and research and**  
16 **take into account new developments in treatment.**

17 (3) **Adjudicate claims for reimbursement of the cost of a treatment based on the approved**  
18 **prior authorization and the information used to approve the prior authorization.**

19 **SECTION 3. A provider who requests prior authorization for an item or health service,**  
20 **an exception from step therapy or other drug protocol or any other coverage that is subject**  
21 **to utilization review may, upon the request of the enrollee, exercise on behalf of the enrollee**

**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.

1 any of the rights of the enrollee for whom the coverage is requested with respect to internal  
2 appeals and external reviews under ORS 743B.250, 743B.252, 743B.255 and 743B.256.

3 **SECTION 4. A written agreement entered into between a third party administrator and**  
4 **an insurer, as described in ORS 744.720, in connection with health insurance coverage must**  
5 **specify the provisions of ORS 743B.250 that will be performed by the insurer and the pro-**  
6 **visions that will be performed by the third party administrator. The insurer is responsible**  
7 **for ensuring compliance with all of the requirements of ORS 743B.250.**

8 **SECTION 5.** ORS 743B.250 is amended to read:

9 743B.250. All insurers offering a health benefit plan in this state shall:

10 (1) Provide to all enrollees directly or in the case of a group policy to the employer or other  
11 policyholder for distribution to enrollees, to all applicants, and to prospective applicants upon re-  
12 quest, the following information:

13 (a) The insurer's written policy on the rights of enrollees, including the right:

14 (A) To participate in decision making regarding the enrollee's health care.

15 (B) To be treated with respect and with recognition of the enrollee's dignity and need for pri-  
16 vacy.

17 (C) To have grievances handled in accordance with this section.

18 (D) To be provided with the information described in this section.

19 (b) An explanation of the procedures described in subsection (2) of this section for making cov-  
20 erage determinations and resolving grievances. The explanation must be culturally and linguistically  
21 appropriate, as prescribed by the department by rule, and must include:

22 (A) The procedures for requesting an expedited response to an internal appeal under subsection  
23 (2)(d) of this section or for requesting an expedited external review of an adverse benefit determi-  
24 nation;

25 (B) A statement that if an insurer does not comply with the decision of an independent review  
26 organization under ORS 743B.256, the enrollee may sue the insurer under ORS 743B.258;

27 (C) The procedure to obtain assistance available from the insurer, if any, and from the Depart-  
28 ment of Consumer and Business Services in filing grievances; and

29 (D) A description of the process for filing a complaint with the department.

30 (c) A summary of benefits and an explanation of coverage in a form and manner prescribed by  
31 the department by rule.

32 (d) A summary of the insurer's policies on prescription drugs, including:

33 (A) Cost-sharing differentials;

34 (B) Restrictions on coverage;

35 (C) Prescription drug formularies;

36 (D) Procedures by which a provider with prescribing authority may prescribe clinically appro-  
37 priate drugs not included on the formulary;

38 (E) Procedures for the coverage of clinically appropriate prescription drugs not included on the  
39 formulary; and

40 (F) A summary of the criteria for determining whether a drug is experimental or investigational.

41 (e) A list of network providers and how the enrollee can obtain current information about the  
42 availability of providers and how to access and schedule services with providers, including clinic  
43 and hospital networks. The list must be available online and upon request in printed format.

44 (f) Notice of the enrollee's right to select a primary care provider and specialty care providers.

45 (g) How to obtain referrals for specialty care in accordance with ORS 743B.227.

- 1 (h) Restrictions on services obtained outside of the insurer's network or service area.
- 2 (i) The availability of continuity of care as required by ORS 743B.225.
- 3 (j) Procedures for accessing after-hours care and emergency services as required by ORS  
4 743A.012.
- 5 (k) Cost-sharing requirements and other charges to enrollees.
- 6 (L) Procedures, if any, for changing providers.
- 7 (m) Procedures, if any, by which enrollees may participate in the development of the insurer's  
8 corporate policies.
- 9 (n) A summary of how the insurer makes decisions regarding coverage and payment for treat-  
10 ment or services, including a general description of any prior authorization and utilization control  
11 requirements that affect coverage or payment.
- 12 (o) Disclosure of any risk-sharing arrangement the insurer has with physicians or other provid-  
13 ers.
- 14 (p) A summary of the insurer's procedures for protecting the confidentiality of medical records  
15 and other enrollee information and the requirement under ORS 743B.555 that a carrier or third  
16 party administrator send communications containing protected health information only to the  
17 enrollee who is the subject of the protected health information.
- 18 (q) An explanation of assistance provided to non-English-speaking enrollees.
- 19 (r) Notice of the information available from the department that is filed by insurers as required  
20 under ORS 743B.200, 743B.202 and 743B.423.
- 21 (2) Establish procedures, in accordance with requirements adopted by the department, for mak-  
22 ing coverage determinations and resolving grievances that provide for all of the following:
- 23 (a) Timely notice of adverse benefit determinations.
- 24 (b) A method for recording all grievances, including the nature of the grievance and significant  
25 action taken.
- 26 (c) Written decisions.
- 27 (d) An expedited response to a request for an internal appeal that accommodates the clinical  
28 urgency of the situation.
- 29 (e) At least one but not more than two levels of internal appeal for group health benefit plans  
30 and one level of internal appeal for individual health benefit plans and for any denial of an exception  
31 to a prescription drug formulary. If an insurer provides:
- 32 (A) Two levels of internal appeal, a person who was involved in the consideration of the initial  
33 denial or the first level of internal appeal may not be involved in the second level of internal appeal;  
34 and
- 35 (B) No more than one level of internal appeal, a person who was involved in the consideration  
36 of the initial denial may not be involved in the internal appeal.
- 37 (f)(A) An external review that meets the requirements of ORS 743B.252, 743B.254 and 743B.255,  
38 after the enrollee has exhausted internal appeals or after the enrollee has been deemed to have  
39 exhausted internal appeals.
- 40 (B) An enrollee shall be deemed to have exhausted internal appeals if an insurer fails to strictly  
41 comply with this section and federal requirements for internal appeals.
- 42 (g) [*The opportunity for*] The enrollee to receive continued coverage of an approved and ongoing  
43 course of treatment under the health benefit plan pending the conclusion of the internal appeal  
44 process.
- 45 (h) The opportunity for the enrollee or any authorized representative chosen by the enrollee to:

1 (A) Submit for consideration by the insurer any written comments, documents, records and other  
2 materials relating to the adverse benefit determination; and

3 (B) Receive from the insurer, upon request and free of charge, reasonable access to and copies  
4 of all documents, records and other information relevant to the adverse benefit determination.

5 (3) Establish procedures for notifying affected enrollees of:

6 (a) A change in or termination of any benefit; and

7 (b)(A) The termination of a primary care delivery office or site; and

8 (B) Assistance available to enrollees in selecting a new primary care delivery office or site.

9 (4) Provide the information described in subsection (2) of this section and ORS 743B.254 at each  
10 level of internal appeal to an enrollee who is notified of an adverse benefit determination or to an  
11 enrollee who files a grievance.

12 (5) Upon the request of an enrollee, applicant or prospective applicant, provide:

13 (a) The insurer's annual report on grievances and internal appeals submitted to the department  
14 under subsection (8) of this section.

15 (b) A description of the insurer's efforts, if any, to monitor and improve the quality of health  
16 services.

17 (c) Information about the insurer's procedures for credentialing network providers.

18 (6) Provide, upon the request of an enrollee, a written summary of information that the insurer  
19 may consider in its utilization review of a particular condition or disease, to the extent the insurer  
20 maintains such criteria. Nothing in this subsection requires an insurer to advise an enrollee how the  
21 insurer would cover or treat that particular enrollee's disease or condition. Utilization review cri-  
22 teria that are proprietary shall be subject to oral disclosure only.

23 (7) Maintain for a period of at least six years written records that document all grievances de-  
24 scribed in ORS 743B.001 [(7)(a)] **(8)(a)** and make the written records available for examination by  
25 the department or by an enrollee or authorized representative of an enrollee with respect to a  
26 grievance made by the enrollee. The written records must include but are not limited to the fol-  
27 lowing:

28 (a) Notices and claims associated with each grievance.

29 (b) A general description of the reason for the grievance.

30 (c) The date the grievance was received by the insurer.

31 (d) The date of the internal appeal or the date of any internal appeal meeting held concerning  
32 the appeal.

33 (e) The result of the internal appeal at each level of appeal.

34 (f) The name of the covered person for whom the grievance was submitted.

35 (8) *[Provide an annual summary to the department of the insurer's aggregate data regarding*  
36 *grievances, internal appeals and requests for external review in a format prescribed by the*  
37 *department]* To ensure consistent reporting on the number, nature and disposition of grievances,  
38 internal appeals and requests for external review, **report to the department annually, in a for-**  
39 **mat prescribed by the department, the following information about requests for prior au-**  
40 **thorization received by the insurer:**

41 **(a) The number of requests received;**

42 **(b) The type of health care providers or the medical specialties of the health care pro-**  
43 **viders submitting requests;**

44 **(c) The items or health services for which the prior authorization was requested, classi-**  
45 **fied by prescription drugs, diagnostic tests or medical procedures;**

1       **(d) The number of requests that were initially denied and the reasons for the denials,**  
2 **including, but not limited to, lack of medical necessity or incomplete requests;**

3       **(e) The number of requests that were initially approved; and**

4       **(f) The number of denials that were reversed by internal appeals or an external reviews.**

5       (9) Allow the exercise of any rights described in this section by an authorized representative.

6       **SECTION 6.** ORS 743B.256 is amended to read:

7       743B.256. (1) An independent review organization shall perform the following duties when ap-  
8 pointed under ORS 743B.252 to review a dispute under a health benefit plan between an insurer and  
9 an enrollee:

10       (a) Decide whether the dispute pertains to an adverse benefit determination and notify the  
11 enrollee and insurer in writing of the decision. If the decision is against the enrollee, the inde-  
12 pendent review organization shall notify the enrollee of the right to file a complaint with or seek  
13 other assistance from the Department of Consumer and Business Services and the availability of  
14 other assistance as specified by the department.

15       (b) Appoint a reviewer or reviewers as determined appropriate by the independent review or-  
16 ganization. **At least one reviewer must be a clinician in the same or similar specialty as the**  
17 **provider who prescribed the treatment that is under review.**

18       (c) Notify the enrollee of information that the enrollee is required to provide and any additional  
19 information the enrollee may provide, and when the information must be submitted as provided in  
20 ORS 743B.252.

21       (d) Notify the insurer of additional information the independent review organization requires and  
22 when the information must be submitted as provided in ORS 743B.252.

23       (e) Decide the dispute relating to the adverse benefit determination of the insurer and issue the  
24 decision in writing.

25       (2) A decision by an independent review organization shall be based on expert medical judgment  
26 after consideration of the enrollee's medical record, the recommendations of each of the enrollee's  
27 providers, relevant medical, scientific and cost-effectiveness evidence and standards of medical  
28 practice in the United States. An independent review organization must make its decision in ac-  
29 cordance with the coverage described in the health benefit plan, except that the independent review  
30 organization may override the insurer's standards for medically necessary or experimental or  
31 investigational treatment if the independent review organization determines that the standards of  
32 the insurer are unreasonable or are inconsistent with sound medical practice.

33       (3) When review is expedited, the independent review organization shall issue a decision not  
34 later than the third day after the date on which the enrollee applies to the insurer for an expedited  
35 review or the Director of the Department of Consumer and Business Services orders an expedited  
36 review.

37       (4) When a review is not expedited, the independent review organization shall issue a decision  
38 not later than the 30th day after the enrollee applies to the insurer for a review or the director  
39 orders a review.

40       (5) An independent review organization shall file synopses of its decisions with the director ac-  
41 cording to the format and other requirements established by the director. The synopses shall exclude  
42 information that is confidential, that is otherwise exempt from disclosure under ORS 192.345 and  
43 192.355 or that may otherwise allow identification of an enrollee. The director shall make the syn-  
44 opses public.

45       **SECTION 7.** ORS 743B.420 is amended to read:

1 743B.420. Except in the case of misrepresentation, prior authorization determinations shall be  
2 subject to the following requirements:

3 (1) Prior authorization determinations relating to benefit coverage and medical necessity shall  
4 be binding on the insurer if obtained no more than [30] **90** days prior to the date the service is  
5 provided.

6 (2) Prior authorization determinations relating to enrollee eligibility shall be binding on the  
7 insurer if obtained no more than five business days prior to the date the service is provided.

8 **SECTION 8.** ORS 743B.423 is amended to read:

9 743B.423. (1) All insurers offering a health benefit plan in this state that provide utilization re-  
10 view or have utilization review provided on their behalf shall file an annual summary with the De-  
11 partment of Consumer and Business Services that describes all utilization review policies, including  
12 delegated utilization review functions, and documents the insurer's procedures for monitoring of  
13 utilization review activities.

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

16 (a) The criteria **and the process** used in the utilization review [*process*] and the method of de-  
17 velopment of the criteria [*shall*] **must:**

18 (A) Be made available for review to contracting providers [*upon request.*];

19 (B) **Be clearly posted on an insurer's website in plain language;**

20 (C) **Be understandable to providers and enrollees; and**

21 (D) **Include:**

22 (i) **All requirements for requesting prior authorization or exceptions to step therapy**  
23 **protocols, including the specific documentation required for a request to be considered**  
24 **complete.**

25 (ii) **A list of the specific services, drugs or devices for which prior authorization is re-**  
26 **quired and a list of the specific drugs for which step therapy is required.**

27 (b) **An insurer must have a website through which a provider makes a secure electronic**  
28 **submission, meeting standards adopted by the department, of a request for prior authori-**  
29 **zation or a request for an exception to a step therapy protocol, along with needed forms and**  
30 **documents. The insurer must provide an electronic receipt to the provider to acknowledge**  
31 **receipt of the request.**

32 (c) **If an insurer deems as incomplete a request for approval of a service or a site where**  
33 **a service may be provided, an insurer must inform the provider of the specific information**  
34 **needed for the request to be considered complete.**

35 [(b)] (d) **An insurer must use** a physician licensed under ORS 677.100 to 677.228 [*shall be re-*  
36 *sponsible for all*] **to make all** final recommendations regarding the necessity or appropriateness of  
37 services or the site at which the services are provided and [*shall consult as appropriate with*] **to**  
38 **consult as needed with the appropriate** medical and mental health specialists in making [*such*]  
39 **the** recommendations.

40 (e) **An insurer must give a provider notice in writing of a denial of a request for approval**  
41 **of a service or site or of an exception to a step therapy protocol. The notice must be written**  
42 **in plain language, be understandable to providers and patients and include the specific reason**  
43 **for the denial based on evidence-based, peer-reviewed literature. If the denial is based on**  
44 **terms in the policy or certificate, the denial must cite the specific language in the policy or**  
45 **certificate.**

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

4        [(d)] (g) [A provider] **Except as provided in paragraph (h) of this subsection, a request for**  
5 **prior authorization of nonemergency service or a request for an exemption from a step therapy**  
6 **protocol must be answered within a reasonable period of time given the medical circumstances**  
7 **but not later than:**

8        (A) Two business days **after receipt of the request**, and qualified health care personnel must  
9 be available for same-day telephone responses to inquiries concerning certification of continued  
10 length of stay; **and**

11        (B) **One business day after receipt of a request for an urgent service, as described in**  
12 **subsection (3) of this section.**

13        (h) **If an insurer requires additional information to make a determination on a request**  
14 **for prior authorization or for an exception to a step therapy protocol, the insurer shall notify**  
15 **the provider and the enrollee in writing, no later than two days after receiving the request,**  
16 **of the additional information needed to make a determination. The insurer shall approve or**  
17 **deny the request by the later of:**

18        (A) **Two business days after receipt of a response from the provider or enrollee to the**  
19 **request for additional information; or**

20        (B) **Fifteen days after the date of the request for additional information.**

21        (i) **If an enrollee is stabilized on a treatment plan, as determined by the treating provider,**  
22 **and the treatment is subject to utilization review, the insurer must continue to provide**  
23 **coverage of the treatment until utilization review is completed and all internal appeals and**  
24 **external reviews are resolved.**

25        (j) **An insurer may not alter utilization review requirements, or initiate or implement**  
26 **new utilization review requirements, without giving a 60-day advance notice to all partic-**  
27 **ipating providers.**

28        (3) **A service is urgent if it is:**

29        (a) **Determined by the requesting provider to be necessary to treat an enrollee's health**  
30 **condition that may seriously jeopardize the enrollee's life, health or ability to regain maxi-**  
31 **mum function; or**

32        (b) **A course of treatment that an enrollee is undergoing using a drug that is not on the**  
33 **insurer's formulary.**

34        **SECTION 9.** ORS 743B.602 is amended to read:

35        743B.602. (1) As used in this section:

36        (a) **"Beneficiary" means an individual receiving health care that is provided or reim-**  
37 **bursed by an entity offering a health care coverage plan.**

38        [(a)] (b) **"Health care coverage plan" includes:**

39        (A) A health benefit plan, as defined in ORS 743B.005;

40        (B) An insurance policy or certificate covering the cost of prescription drugs, hospital expenses,  
41 health care services and medical expenses, equipment and supplies;

42        (C) A medical services contract, as defined in ORS 743B.001;

43        (D) A multiple employer welfare arrangement, as defined in ORS 750.301;

44        (E) A contract or agreement with a health care service contractor, as defined in ORS 750.005,  
45 or a preferred provider organization;

1 (F) A pharmacy benefit manager, as defined in ORS 735.530, or other third party administrator  
2 that pays prescription drug claims; and

3 (G) An accident insurance policy or any other insurance contract providing reimbursement for  
4 the cost of prescription drugs, hospital expenses, health care services and medical expenses, equip-  
5 ment and supplies.

6 *[(b) "Step therapy" means a drug protocol in which a health care coverage plan will reimburse the  
7 cost of a prescribed drug only if the patient has first tried a specified drug or series of drugs.]*

8 *[(2) A health care coverage plan that requires step therapy shall make easily accessible to pre-  
9 scribing practitioners, clear explanations of:]*

10 **(2) An entity that offers a health care coverage plan that requires step therapy shall post  
11 to the website of the plan clear explanations, that are easily accessible to prescribing prac-  
12 titioners and beneficiaries of the plan, written in plain language and understandable to  
13 practitioners and beneficiaries, of:**

14 (a) The clinical criteria for each step therapy protocol **and the criteria for approving an ex-  
15 ception to the protocol;**

16 (b) The procedure by which a practitioner may submit to the plan, **in accordance with sub-  
17 section (3) of this section**, the practitioner's medical rationale for determining that a particular  
18 step therapy protocol is not appropriate for a particular [*patient*] **beneficiary** based on the  
19 [*patient's*] **beneficiary's** medical condition and history; and

20 (c) The documentation, if any, that a practitioner must submit to the plan for the plan to de-  
21 termine the appropriateness of step therapy for a specific [*patient*] **beneficiary**.

22 **(3) If a health care coverage plan restricts the use of a prescription drug for the treat-  
23 ment of a medical condition by imposing a step therapy protocol for the use, the entity shall  
24 provide a clear, readily accessible and convenient process for the prescribing practitioner to  
25 request an exception to the step therapy protocol. The entity may use its existing process  
26 for practitioners to request exceptions to other coverage restrictions or limitations.**

27 **(4) An entity offering a health care coverage plan must approve a request for an excep-  
28 tion to a step therapy protocol if the prescribing practitioner submits sufficient evidence to  
29 establish that:**

30 (a) **The prescription drug required by the protocol is contraindicated or is likely to cause  
31 the beneficiary to experience an adverse reaction or physical or mental harm;**

32 (b) **The prescription drug required by the protocol is expected to be ineffective based on  
33 the known clinical characteristics of the beneficiary and the known characteristics of the  
34 prescription drug regimen;**

35 (c) **The beneficiary has tried the drug required by the protocol while covered under the  
36 beneficiary's current or prior health care coverage plan, or tried another prescription drug  
37 in the same pharmacologic class or with the same mechanism of action, and the beneficiary's  
38 use of the prescription drug was discontinued due to the lack of efficacy or a diminished ef-  
39 fect or because the beneficiary experienced an adverse event;**

40 (d) **The beneficiary is experiencing, or while covered by the beneficiary's previous health  
41 care coverage plan was experiencing, a positive therapeutic outcome using the prescription  
42 drug for which the beneficiary's prescribing provider has requested the exception; or**

43 (e) **The beneficiary's use of the prescription drug required by the protocol is not in the  
44 best interest of the beneficiary based on documentation showing that the beneficiary's use  
45 of the prescription drug is expected to:**

- 1 (A) Create a barrier to the beneficiary's adherence or compliance with the plan of care;
- 2 (B) Negatively impact a comorbid condition of the beneficiary;
- 3 (C) Cause a negative drug interaction that is clinically predictable; or
- 4 (D) Decrease the beneficiary's ability to achieve or maintain the reasonable functional
- 5 ability to perform daily activities.

6 (5) A prescribing practitioner may not use a pharmaceutical sample for the sole purpose

7 of qualifying for an exception to a step therapy protocol under subsection (4)(c) or (d) of this

8 section.

9 (6) A health care coverage plan must cover the prescription drug requested by the pre-

10 scribing practitioner upon the approval of the practitioner's request for an exception.

11 (7) This section does not prevent:

12 (a) A health care coverage plan from requiring a beneficiary to try an AB-rated generic

13 equivalent or a biological product that is an interchangeable biological product prior to cov-

14 ering the equivalent brand name prescription drug;

15 (b) A health care coverage plan from denying a request for an exception to allow cover-

16 age of a drug that has been removed from the market due to the safety concerns of the

17 United States Food and Drug Administration; or

18 (c) A practitioner from prescribing a prescription drug that is medically appropriate.

19 **SECTION 10.** ORS 743B.001 is amended to read:

20 743B.001. As used in this section and ORS 743.008, 743.035, **743A.067**, 743B.195, 743B.197,

21 743B.200, 743B.202, 743B.204, 743B.220, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 743B.254,

22 743B.255, 743B.256, 743B.257, 743B.258, 743B.310, 743B.400, 743B.403, 743B.405, 743B.420, 743B.422,

23 743B.423, 743B.424, 743B.450, 743B.451, 743B.452, 743B.453, 743B.454, 743B.505, 743B.550, [and]

24 743B.555 and **743B.602 and sections 2 and 3 of this 2019 Act:**

25 (1) "Adverse benefit determination" means an insurer's denial, reduction or termination of a

26 health care item or service, or an insurer's failure or refusal to provide or to make a payment in

27 whole or in part for a health care item or service, that is based on the insurer's:

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

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

30 (c) Imposition of a preexisting condition exclusion as defined in ORS 743B.005, source-of-injury

31 exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or

32 services;

33 (d) Determination that a health care item or service is experimental, investigational or not

34 medically necessary, effective or appropriate; or

35 (e) Determination that a course or plan of treatment that an enrollee is undergoing is an active

36 course of treatment for purposes of continuity of care under ORS 743B.225.

37 (2) "Authorized representative" means an individual who by law or by the consent of a person

38 may act on behalf of the person.

39 (3) "Clinical review criteria" means screening procedures, decision rules, medical proto-

40 cols and clinical guidance used by an insurer or other entity in conducting utilization review,

41 in evaluating:

42 (a) Medical necessity;

43 (b) Appropriateness of an item or health service for which prior authorization is re-

44 quested or for which an exception to a step therapy protocol has been requested as described

45 in ORS 743B.602; or

1       **(c) Any other coverage that is subject to utilization review.**

2       [(3)] (4) “Credit card” has the meaning given that term in 15 U.S.C. 1602.

3       [(4)] (5) “Electronic funds transfer” has the meaning given that term in ORS 293.525.

4       [(5)] (6) “Enrollee” has the meaning given that term in ORS 743B.005.

5       [(6)] (7) “Essential community provider” has the meaning given that term in rules adopted by  
6 the Department of Consumer and Business Services consistent with the description of the term in  
7 42 U.S.C. 18031 and the rules adopted by the United States Department of Health and Human Ser-  
8 vices, the United States Department of the Treasury or the United States Department of Labor to  
9 carry out 42 U.S.C. 18031.

10       [(7)] (8) “Grievance” means:

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

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

15       (B) In writing or orally, for an expedited response described in ORS 743B.250 (2)(d) or an expe-  
16 dited external review; or

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

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

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

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

24       [(8)] (9) “Health benefit plan” has the meaning given that term in ORS 743B.005.

25       [(9)] (10) “Independent practice association” means a corporation wholly owned by providers,  
26 or whose membership consists entirely of providers, formed for the sole purpose of contracting with  
27 insurers for the provision of health care services to enrollees, or with employers for the provision  
28 of health care services to employees, or with a group, as described in ORS 731.098, to provide health  
29 care services to group members.

30       [(10)] (11) “Insurer” includes a health care service contractor as defined in ORS 750.005.

31       [(11)] (12) “Internal appeal” means a review by an insurer of an adverse benefit determination  
32 made by the insurer.

33       [(12)] (13) “Managed health insurance” means any health benefit plan that:

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

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

40       (14) **“Medical necessity” means health services, items or supplies that are appropriate,**  
41 **according to applicable standards of care:**

42       (a) **To improve or preserve life, health or function;**

43       (b) **To slow the deterioration of health or function; or**

44       (c) **For the early screening, prevention, evaluation, diagnosis or treatment of a disease,**  
45 **illness, injury or other health condition.**

1 [(13)] (15) “Medical services contract” means a contract between an insurer and an independent  
 2 practice association, between an insurer and a provider, between an independent practice associ-  
 3 ation and a provider or organization of providers, between medical or mental health clinics, and  
 4 between a medical or mental health clinic and a provider to provide medical or mental health ser-  
 5 vices. “Medical services contract” does not include a contract of employment or a contract creating  
 6 legal entities and ownership thereof that are authorized under ORS chapter 58, 60 or 70, or other  
 7 similar professional organizations permitted by statute.

8 [(14)(a)] (16)(a) “Preferred provider organization insurance” means any health benefit plan that:

9 (A) Specifies a preferred network of providers managed, owned or under contract with or em-  
 10 ployed by an insurer;

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

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

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

19 [(15)] (17) “Prior authorization” means a determination by an insurer prior to provision of ser-  
 20 vices that the insurer will provide reimbursement for the services. “Prior authorization” does not  
 21 include referral approval for evaluation and management services between providers.

22 [(16)(a)] (18)(a) “Provider” means a person licensed, certified or otherwise authorized or per-  
 23 mitted by laws of this state to administer medical or mental health services in the ordinary course  
 24 of business or practice of a profession.

25 (b) With respect to the statutes governing the billing for or payment of claims, “provider” also  
 26 includes an employee or other designee of the provider who has the responsibility for billing claims  
 27 for reimbursement or receiving payments on claims.

28 (19) **“Step therapy” means a protocol, policy or program that establishes a sequence in**  
 29 **which the cost of prescription drugs for a specific medical condition will be reimbursed by**  
 30 **an insurer.**

31 [(17)] (20) “Utilization review” means a set of formal techniques used by an insurer or delegated  
 32 by the insurer designed to monitor the use of or evaluate the medical necessity, appropriateness,  
 33 efficacy or efficiency of health care services, procedures or settings.

34 **SECTION 11.** ORS 743.035 is amended to read:

35 743.035. (1) The Department of Consumer and Business Services, in consultation with the Oregon  
 36 Health Authority, shall develop by rule a form that providers in this state shall use to request prior  
 37 authorization for prescription drug benefits. The form must:

38 (a) Be uniform for all providers;

39 (b) Not exceed two pages;

40 (c) Be electronically available and transmissible; and

41 (d) Include a provision under which additional information may be requested and provided.

42 (2) If a person described in ORS 743.029 (2) requires prior authorization for prescription drug  
 43 benefits, the person must allow the use of the form developed under subsection (1) of this section.

44 (3) An insurer meets the requirement set forth in ORS 743B.423 [(2)(d)] (2)(g) if the insurer an-  
 45 swers a provider’s request for prior authorization within two business days of having received a

1 completed form developed under subsection (1) of this section and all supporting documentation  
2 needed to process the request.

3 (4) The department may adopt rules to implement this section.

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