PRELIMINARY

HB 4102 -2 STAFF MEASURE SUMMARY

House Committee On Health Care

Prepared By: Oliver Droppers, LPRO Analyst
Meeting Dates: 2/4, 2/6, 2/11

WHAT THE MEASURE DOES:
Requires coordinated care organizations (CCOs) to annually report to Oregon Health Authority (OHA) the number of requests for prior authorization including initial and reserved denials, grievances or contested case hearings. Requires insurers to submit to Department of Consumer and Business Services (DCBS) the number of: (1) requests for prior authorization received, (2) initial denials and reasons for denial of prior authorizations, (3) approved requests, and (4) denials reversed. Modifies grievance and appeal dispute process among insurers and enrollees by requiring an independent review organization to have at least one reviewer be a clinician in the same or similar specialty as the provider who prescribed the contested treatment. Modifies utilization review requirements for insurers; requires insurers to post online requirements for and list of treatments, drugs, or devices subject to utilization review; requires insurers to notify provider(s) of a denial in writing using plain language; prohibits insurers from altering utilization review requirements without a 60-day advance notice; and modifies step therapy coverage guidelines. Modifies definition of prior authorization, defines step therapy. Takes effect on the 91st day after sine die.

ISSUES DISCUSSED:
- Senate Bill 139 (2019); ongoing discussions in the 2019-20 interim
- Use of utilization management including step therapy for certain diseases
- Possible amendments

EFFECT OF AMENDMENT:
-2 Modifies requirements for coordinated care organizations annual reporting on the number of prior authorization denials that are appealed. Modifies insurers reporting requirements for denials of prior authorizations based on failure to provide additional clinical information if requested by insurer. Specifies certain provisions of the measure do not apply to health plans offered by Public Employees' Benefit Board and Oregon Educators Benefit Board: website requirement, electronic submission for providers for utilization management requests, and approval for prescription drugs for at least 12 months if certain if certain conditions have been met.

REVENUE: Revenue impact statement issued: no impact.
FISCAL: Fiscal impact statement issued: minimal impact.

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, DCBS regulated health insurers covering approximately 1 million Oregonians in the individual, small group, large group, associations, and trusts markets.

Health insurers use utilization management to control costs and assure quality of services, most often in the form of prior authorization that requires approval of certain items or services before the insured can receive them. Similarly, step therapy protocols are used to help manage costs and risks associated with prescription drugs by requiring initial utilization of the most cost-effective drug and progressing to alternative drugs only if necessary. According to the Oregon Medical Association, based on a recent survey of its members, the types of treatments, drugs, and devices that are subject to utilization review has increased, thus impacting patient care.

House Bill 4102 modifies utilization management protocols among insurers, providers, and enrollees.

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