

HB 4102 A STAFF MEASURE SUMMARY

Senate Committee On Health Care

Prepared By: Brian Nieuburt, LPRO Analyst

Meeting Dates: 2/25

WHAT THE MEASURE DOES:

Requires coordinated care organizations (CCOs) to annually report to Oregon Health Authority the number of requests for prior authorization, including initial and reserved denials and reasons for denials. Requires insurers to submit to Department of Consumer and Business Services 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. Specifies certain provisions of the measure do not apply to health plans offered by Public Employees' Benefit Board and Oregon Educators Benefit Board. Modifies definition of prior authorization; defines step therapy. Takes effect on the 91st day following adjournment sine die.

REVENUE: No revenue impact

FISCAL: Has minimal fiscal 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, 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 have increased, thus impacting patient care.

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