HB 4016-A9
(LC 130)
2/19/20 (LHF/ps)

Requested by Representative KOTEK

PROPOSED AMENDMENTS TO
A-ENGROSSED HOUSE BILL 4016

On page 1 of the printed A-engrossed bill, line 2, delete "and" and insert a comma.

In line 3, after "690.015" delete the rest of the line and insert ", 743A.064, 743B.001 and 743B.425; and declaring an emergency.".

On page 4, after line 43, insert:

"SECTION 5. ORS 743A.064 is amended to read:

"743A.064. **(1) As used in this section, 'urgent medical condition' means a medical condition that arises suddenly, is not life-threatening and requires prompt treatment to avoid the development of more serious medical problems.**

"[*(1)*] **(2)** All health insurance policies that provide a prescription drug benefit, except those policies in which coverage is limited to expenses from accidents or specific diseases that are unrelated to the coverage required by this subsection, must include coverage for prescription drugs**:**

"(a) Dispensed by a licensed practitioner at a rural health clinic for an urgent medical condition if there is not a pharmacy within 15 miles of the clinic or if the prescription is dispensed for a patient outside of the normal business hours of any pharmacy within 15 miles of the clinic**; and**

"(b) Prescribed and dispensed by a licensed pharmacist if the State Board of Pharmacy or any state law authorizes the drug to be prescribed and dispensed by pharmacists licensed in this state.

"**(3) The coverage described in subsection (2)(b) of this section must include reimbursement of a pharmacist's reasonable fees for consulting with a patient.**

"[*(2)*] **(4)** The coverage required by subsection [*(1)*] **(2)** of this section is subject to the terms and conditions of the prescription drug benefit provided under the policy**, which may include a condition that a pharmacist prescribing a drug under subsection (2)(b) of this section document the patient visit and certify that the pharmacist made a reasonable attempt to inform the patient's primary care provider of the prescription**.

"[*(3) As used in this section, 'urgent medical condition' means a medical condition that arises suddenly, is not life-threatening and requires prompt treatment to avoid the development of more serious medical problems.*]

"**(5) This section is exempt from ORS 743A.001.**

"SECTION 6. ORS 743B.425 is amended to read:

"743B.425. (1) [*In reimbursing the cost of medication prescribed for the purpose of treating opioid or opiate withdrawal,*] An insurer offering a health benefit plan as defined in ORS 743B.005 may not**:**

"(a) Require prior authorization [*of payment during*] **for:**

"(A) The first 30 days of [*treatment*] **medication prescribed for the purpose of treating opioid or opiate withdrawal; or**

"(B) Post-exposure prophylaxes antiretroviral drugs; or

"(b) Restrict the reimbursement for medication-assisted treatments or drugs described in this subsection to in-network pharmacists or pharmacies.

"(2) This section is not subject to ORS 743A.001.

"(3) [*Nothing in this section shall be interpreted to*] **This section does not** prohibit**:**

"(a) Prior authorization for reimbursement for payment for prescribing opioids or opiates for purposes other than medical management or treatment

of opioid or opiate abuse or addiction**; or**

"(b) Utilization review including, but not limited to, formularies or limits on quantities.

"SECTION 7. ORS 743B.001 is amended to read:

"743B.001. As used in this section and ORS 743.008, 743.029, 743.035, 743A.190, 743B.195, 743B.197, 743B.200, 743B.202, 743B.204, 743B.220, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.310, 743B.400, 743B.403, 743B.405, 743B.420, 743B.422, 743B.423, 743B.424, **743B.425,** 743B.450, 743B.451, 743B.452, 743B.453, 743B.454, 743B.505, 743B.550 and 743B.555 and section 2, chapter 771, Oregon Laws 2013:

"(1) 'Adverse benefit determination' means an insurer's denial, reduction or termination of a health care item or service, or an insurer's failure or refusal to provide or to make a payment in whole or in part for a health care item or service, that is based on the insurer's:

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

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

"(c) Imposition of a preexisting condition exclusion as defined in ORS 743B.005, source-of-injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or services;

"(d) Determination that a health care item or service is experimental, investigational or not medically necessary, effective or appropriate;

"(e) Determination that a course or plan of treatment that an enrollee is undergoing is an active course of treatment for purposes of continuity of care under ORS 743B.225; or

"(f) Denial, in whole or in part, of a request for prior authorization.

"(2) 'Authorized representative' means an individual who by law or by the consent of a person may act on behalf of the person.

"(3) 'Credit card' has the meaning given that term in 15 U.S.C. 1602.

"(4) 'Electronic funds transfer' has the meaning given that term in ORS

293.525.

"(5) 'Enrollee' has the meaning given that term in ORS 743B.005.

"(6) 'Essential community provider' has the meaning given that term in rules adopted by the Department of Consumer and Business Services consistent with the description of the term in 42 U.S.C. 18031 and the rules adopted by the United States Department of Health and Human Services, the United States Department of the Treasury or the United States Department of Labor to carry out 42 U.S.C. 18031.

"(7) 'Grievance' means:

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

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

"(B) In writing or orally, for an expedited response described in ORS 743B.250 (2)(d) or an expedited external review; or

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

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

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

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

"(8) 'Health benefit plan' has the meaning given that term in ORS 743B.005.

"(9) 'Independent practice association' means a corporation wholly owned by providers, or whose membership consists entirely of providers, formed for the sole purpose of contracting with insurers for the provision of health care services to enrollees, or with employers for the provision of health care services to employees, or with a group, as described in ORS 731.098, to provide

health care services to group members.

"(10) 'Insurer' includes a health care service contractor as defined in ORS 750.005.

"(11) 'Internal appeal' means a review by an insurer of an adverse benefit determination made by the insurer.

"(12) 'Managed health insurance' means any health benefit plan that:

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

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

"(13) 'Medical services contract' means a contract between an insurer and an independent practice association, between an insurer and a provider, between an independent practice association and a provider or organization of providers, between medical or mental health clinics, and between a medical or mental health clinic and a provider to provide medical or mental health services. 'Medical services contract' does not include a contract of employment or a contract creating legal entities and ownership thereof that are authorized under ORS chapter 58, 60 or 70, or other similar professional organizations permitted by statute.

"(14)(a) 'Preferred provider organization insurance' means any health benefit plan that:

"(A) Specifies a preferred network of providers managed, owned or under contract with or employed by an insurer;

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

"(C) Creates financial incentives for an enrollee to use the preferred

network of providers by providing an increased level of benefits.

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

"(15) 'Prior authorization' means a determination by an insurer upon request by a provider or an enrollee, prior to the provision of health care that is subject to utilization review, that the insurer will provide reimbursement for the health care requested. 'Prior authorization' does not include referral approval for evaluation and management services between providers.

"(16)(a) 'Provider' means a person licensed, certified or otherwise authorized or permitted by laws of this state to administer medical or mental health services in the ordinary course of business or practice of a profession.

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

"(17) 'Utilization review' means a set of formal techniques used by an insurer or delegated by the insurer designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy or efficiency of health care items, services, procedures or settings.

"SECTION 8. ORS 743B.001, as amended by section 12, chapter 284, Oregon Laws 2019, is amended to read:

"743B.001. As used in this section and ORS 743.008, 743.029, 743.035, 743A.190, 743B.195, 743B.197, 743B.200, 743B.202, 743B.204, 743B.220, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.310, 743B.400, 743B.403, 743B.405, 743B.420, 743B.422, 743B.423, 743B.424, **743B.425,** 743B.450, 743B.451, 743B.452, 743B.453, 743B.454, 743B.505, 743B.550 and 743B.555:

"(1) 'Adverse benefit determination' means an insurer's denial, reduction or termination of a health care item or service, or an insurer's failure or refusal to provide or to make a payment in whole or in part for a health care item or service, that is based on the insurer's:

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

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

"(c) Imposition of a preexisting condition exclusion as defined in ORS 743B.005, source-of-injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or services;

"(d) Determination that a health care item or service is experimental, investigational or not medically necessary, effective or appropriate;

"(e) Determination that a course or plan of treatment that an enrollee is undergoing is an active course of treatment for purposes of continuity of care under ORS 743B.225; or

"(f) Denial, in whole or in part, of a request for prior authorization.

"(2) 'Authorized representative' means an individual who by law or by the consent of a person may act on behalf of the person.

"(3) 'Credit card' has the meaning given that term in 15 U.S.C. 1602.

"(4) 'Electronic funds transfer' has the meaning given that term in ORS 293.525.

"(5) 'Enrollee' has the meaning given that term in ORS 743B.005.

"(6) 'Essential community provider' has the meaning given that term in rules adopted by the Department of Consumer and Business Services consistent with the description of the term in 42 U.S.C. 18031 and the rules adopted by the United States Department of Health and Human Services, the United States Department of the Treasury or the United States Department of Labor to carry out 42 U.S.C. 18031.

"(7) 'Grievance' means:

"(a) A communication from an enrollee or an authorized representative

of an enrollee expressing dissatisfaction with an adverse benefit determination, without specifically declining any right to appeal or review, that is:

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

"(B) In writing or orally, for an expedited response described in ORS 743B.250 (2)(d) or an expedited external review; or

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

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

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

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

"(8) 'Health benefit plan' has the meaning given that term in ORS 743B.005.

"(9) 'Independent practice association' means a corporation wholly owned by providers, or whose membership consists entirely of providers, formed for the sole purpose of contracting with insurers for the provision of health care services to enrollees, or with employers for the provision of health care services to employees, or with a group, as described in ORS 731.098, to provide health care services to group members.

"(10) 'Insurer' includes a health care service contractor as defined in ORS 750.005.

"(11) 'Internal appeal' means a review by an insurer of an adverse benefit determination made by the insurer.

"(12) 'Managed health insurance' means any health benefit plan that:

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

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

"(13) 'Medical services contract' means a contract between an insurer and an independent practice association, between an insurer and a provider, between an independent practice association and a provider or organization of providers, between medical or mental health clinics, and between a medical or mental health clinic and a provider to provide medical or mental health services. 'Medical services contract' does not include a contract of employment or a contract creating legal entities and ownership thereof that are authorized under ORS chapter 58, 60 or 70, or other similar professional organizations permitted by statute.

"(14)(a) 'Preferred provider organization insurance' means any health benefit plan that:

"(A) Specifies a preferred network of providers managed, owned or under contract with or employed by an insurer;

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

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

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

"(15) 'Prior authorization' means a determination by an insurer upon request by a provider or an enrollee, prior to the provision of health care that is subject to utilization review, that the insurer will provide reimbursement for the health care requested. 'Prior authorization' does not include referral

approval for evaluation and management services between providers.

"(16)(a) 'Provider' means a person licensed, certified or otherwise authorized or permitted by laws of this state to administer medical or mental health services in the ordinary course of business or practice of a profession.

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

"(17) 'Utilization review' means a set of formal techniques used by an insurer or delegated by the insurer designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy or efficiency of health care items, services, procedures or settings.".

In line 44, delete "5" and insert "9".

On page 5, delete lines 7 and 8 and insert:

"SECTION 10. The amendments to ORS 743A.064 and 743B.425 by sections 5 and 6 of this 2020 Act apply to policies and certificates issued, renewed or extended on or after January 1, 2021.

"SECTION 11 This 2020 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2020 Act takes effect on its passage.".
