HB 2517 -1 STAFF MEASURE SUMMARY

House Committee On Health Care

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Meeting Dates: 3/4, 4/6

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 reversed 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. Modifies definition of "prior authorization" and "health care coverage plan"; defines "step therapy" and "clinical review criteria." Takes effect on the 91st day following adjournment sine die.

ISSUES DISCUSSED:

- Prior authorization and step therapy as cost control provisions
- Exclusion of Oregon Health Plan members
- Associated care delays due to the administrative burden with prior authorization
- Step therapy and medical necessity exceptions
- 72 hour timeline to approve or deny prior authorizations with exceptions requirement

EFFECT OF AMENDMENT:

-1 Requires Oregon Health Authority to report on the number of requests for prior authorization, including initial and reversed denials and reasons for denials as reported to the agency by CCOs. Clarifies timeline for insurers to approve or deny exception for step therapy.

REVENUE: statement issued - no revenue impact.

FISCAL: statement issued - see explanatory statement.

BACKGROUND:

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 past survey of its members, the types of treatments, drugs, and devices that are subject to utilization review have increased, thus impacting patient care. In 2019, Senate Bill 249 passed prohibiting certain conduct by health insurers when reviewing and responding to requests for prior authorization, including: (1) clarifying the timeline for handling prior authorizations, and (2) creating a transparent process for prior authorization requests for patients, insurers, and providers.

House Bill 2517 modifies utilization management protocols among insurers, providers, and enrollees including use of prior authorization and step therapy.