HB 3134 -1 STAFF MEASURE SUMMARY

House Committee On Behavioral Health and Health Care

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Meeting Dates: 3/27, 4/3

WHAT THE MEASURE DOES:

The measure creates a process that exempts certain health care providers from requirement to obtain prior authorization (PA) from the patient's health insurer.

Detailed Summary

- Requires insurers to exempt a health care provider from PA requirements if the insurer has approved 80 percent of the providers PA request during the previous 12-month period. Requires exemption to be for no less than 12 months.
- Prohibits insurer from requiring provider to apply or otherwise request exemption and prohibits insurer reconsideration of exemption more than once in a 12-month period.
- Specifies that exemption may be revoked or discontinued only if specified recent claims do no meat insurer's PA criteria and the provider is notified of claims' insufficiency and how to request appeal of determination. Requires determinations to deny, revoke, or discontinue an exemption to be reviewed by a licensed provider operating within their scope of practice.
- Requires the Department of Consumer and Business Services (DCBS) to make annual insurer reports publicly available. Adds elements to insurer's annual reporting requirements to include the number of days it took to make a PA determination; the number of appeals from revocation, denial, or discontinuation of PA exemptions; and the time spent reviewing appeals of PA exemption revocations or denials.
- Permits DCBS Director to enforce the adjudication of health insurance benefits in matters arising from health insurance assignees or health care clearinghouses.
- Adds rendering a determination of medical necessity to definition of practice of medicine.
- Requires insurer to cover approved requests for coverage of a prescription drug or treatment of a degenerative disease or condition until the disease or condition is cured or the patient dies.
- Applies PA exemption requirements to plans offered by the Public Employees' Benefit Board (PEBB), Oregon Educators Benefit Board (OEBB), and coordinated care organizations (CCOs); requires OHA to include information regarding number of days CCOs took reviewing a PA request in annual reporting to OHA website.
- Takes effect on 91st day following adjournment sine die.

Fiscal impact: May have fiscal impact, but no statement yet issued
Revenue impact: May have revenue impact, but no statement yet issued

ISSUES DISCUSSED:

EFFECT OF AMENDMENT:

-1 **Replaces the measure.**

- Expands duration that PA decisions are binding no insurer from 60 days to 12 months.
- Clarifies information that must be posted to insurers' websites.
- Prohibits insurers from requiring additional PA for procedures related to a surgery that has been approved by the insurer.
- Requires insurers to utilize a PA application programming interface that enables providers to determine whether a PA is required, identify needed information or documentation for PA request, and transfer PA requests and determinations from the provider's electronic health record (EHR) system. Requires insurers to respond to PA request through the application programming interface.

- Requires insurers to annually review services that are subject to utilization review and remove any requirement that interferes with access to quality health care, does not reduce disparities, or is primarily for the insurer's economic benefit. Requires insurers to submit annual report to DCBS affirming review has occurred and indicating any PA requirements that were removed.
- Requires insurers to institute a Prior Authorization Reduction Program by July 1, 2026. Specifies that program shall be developed by insurers in consultation with in-network providers, define which providers are eligible to participate, eliminate or modify PA requirements to reduce administrative burden for providers and beneficiaries, and identify services or benefits that should have PA requirements reduced or eliminated based on provider performance and specialty/experience. Requires insurers to begin posting specified information regarding Prior Authorization Reduction Program beginning July 1, 2026.
- Prohibits insurers from requiring PA for rehabilitative or habilitative services for the first 12 visits of each new episode of care; after first 12 visits prohibits requiring PA more frequently than every six visits or once every 30 days, whichever is longer. Prohibits insurers from requiring PA for chronic pain rehabilitative or habilitative services for the 90 days immediately following diagnosis; after 90 days prohibits requiring PA more frequently than every six visits or once every 30 days, whichever is longer. Requires insurers to issue determination or request additional information within 24 hours of receiving PA request.
- Applies requirements to plans offered by the Public Employees' Benefit Board (PEBB), Oregon Educators Benefit Board (OEBB), health care service contractors, and multiple employer welfare arrangements (MEWAs)

BACKGROUND:

Prior authorization refers to the process by which a health insurance plan requires a health care provider to obtain approval prior to performing a service or prescribing a medication. Proponents of prior authorization requirements note that they can help ensure services are necessary and being provided in a cost-effect manner. Critics of prior authorization indicate that the requirements can hinger patients' access to necessary care and add to the administrative burden for both providers and patients.

House Bill 3134 creates a process that exempts certain health care providers from requirement to obtain prior authorization from the patient's health insurer.