HB 3134 STAFF MEASURE SUMMARY

House Committee On Behavioral Health and Health Care

Prepared By: Brian Nieubuurt, LPRO Analyst
Meeting Dates: 3/27, 4/8

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.

ISSUES DISCUSSED:

- Burden of prior authorization on providers and potential negative impacts on patient care.
- Upcoming CMS rules.
- Examples of unnecessary care.

EFFECT OF AMENDMENT:

No amendment.

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.