A-Engrossed
House Bill 2292

Ordered by the House April 7
Including House Amendments dated April 7

Sponsored by Representative GRAYBER; Representatives MCDONALD, NELSON, PHAM H, Senator PHAM K
(Presession filed.)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure. The statement includes a measure digest written in compliance with applicable readability standards.

Digest: Tells some health insurers and Medicaid plans to cover more drugs and treatment for HIV. (Flesch Readability Score: 73.1).

Requires health benefit plans and medical assistance managed plans to provide coverage with no cost-sharing for additional treatment for human immunodeficiency virus and prohibits requiring prior authorization.

A BILL FOR AN ACT

Relating to treatment of human immunodeficiency virus; creating new provisions; and amending ORS 743B.001 and 743B.425.

Be It Enacted by the People of the State of Oregon:

SECTION 1. Section 2 of this 2025 Act is added to and made a part of the Insurance Code.

SECTION 2. (1) An insurer that offers a health benefit plan, as defined in ORS 743B.005, that reimburses the cost of counseling, prevention services or screening for sexually transmitted infections, shall provide coverage for:

(a) Drugs that have been approved by the United States Food and Drug Administration for the prevention of human immunodeficiency virus;

(b) Services necessary for the commencement or continuation of human immunodeficiency virus prevention drugs described in this section, including but not limited to office visits, testing, vaccinations and monitoring services; and

(c) Drugs that have been approved by the United States Food and Drug Administration for the treatment of human immunodeficiency virus.

(2) The coverage under subsection (1)(a) and (b) of this section must be provided without cost-sharing, coinsurance or deductibles applicable to the services.

(3) This section is exempt from ORS 743A.001.

SECTION 3. ORS 743B.425 is amended to read:

743B.425. (1) An insurer offering a health benefit plan [*as defined in ORS 743B.005*] may not:

(a) Require prior authorization:

(A) During the first 60 days of treatment, including medication therapy, prescribed for opioid or opiate withdrawal; or

(B) For post-exposure prophylactic antiretroviral drugs or [*at least one*] preexposure prophylactic antiretroviral [*drug*] **drugs, or drugs prescribed for the treatment of human immunodeficiency virus or acquired immunodeficiency syndrome**; **or**

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

(b) Restrict the reimbursement for medication therapies, preexposure prophylactic antiretroviral drugs or post-exposure prophylactic antiretroviral drugs to in-network pharmacists or pharmacies[*; or*]**.**

[*(c) Subject to ORS 742.008, require a deductible, copayment, coinsurance or other cost-sharing for the coverage of human immunodeficiency virus post-exposure prophylactic drugs or therapies prescribed following a possible exposure to human immunodeficiency virus.*]

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

(3) This section does not prohibit prior authorization for opioids or opiates prescribed for purposes other than medication therapy or treatment of opioid or opiate abuse or addiction.

(4) Subsection (1)(b) of this section does not apply to a health maintenance organization as defined in ORS 750.005.

SECTION 4. Section 5 of this 2025 Act is added to and made a part of ORS chapter 414.

SECTION 5. (1) As used in this section:

(a) "Prior authorization" has the meaning given that term in ORS 743B.001.

(b) "Step therapy" has the meaning given that term in ORS 743B.001.

(2) Notwithstanding ORS 414.325, the Oregon Health Authority and a coordinated care organization may not require prior authorization or step therapy for drugs prescribed for a medical assistance recipient for the treatment or prevention of human immunodeficiency virus if:

(a) The drug has been approved by the United States Food and Drug Administration for the treatment or prevention of human immunodeficiency virus; and

(b) The prescribing provider has determined that the drug is medically necessary.

(3) Nothing in this section prevents the authority or a coordinated care organization from performing drug utilization review that may be necessary for patient safety or for ensuring the prescribed drug is medically accepted as required by section 1927 of the Social Security Act of 1935 (42 U.S.C. 1396r-8).

SECTION 6. ORS 743B.001, as amended by section 3, chapter 35, Oregon Laws 2024, 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, 743B.555 and 743B.602 and section 2, chapter 35, Oregon Laws 2024:

(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, a request for an exception to step therapy or a request for coverage of a treatment, drug, device or diagnostic or laboratory test that is subject to other utilization review requirements.

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

(3) "Clinical review criteria" means screening procedures, decision rules, medical protocols and clinical guidance used by an insurer or other entity in conducting utilization review and evaluating:

(a) Medical necessity;

(b) Appropriateness of an item or health service for which prior authorization is requested or for which an exception to step therapy has been requested as described in ORS 743B.602; or

(c) Any other coverage that is subject to utilization review.

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

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

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

(7) "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.

(8) "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.

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

(10) "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.

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

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

(13) "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.

(14) "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.

(15)(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.

(16) "Prior authorization" means a form of utilization review that requires a provider or an enrollee to request a determination by an insurer, 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.

(17)(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.

(18) "Step therapy" means a utilization review protocol, policy or program in which an insurer requires certain preferred drugs for treatment of a specific medical condition be proven ineffective or contraindicated before a prescribed drug may be reimbursed.

(19) "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 7. Section 2 of this 2025 Act and the amendments to ORS 743B.425 by section 3 of this 2025 Act apply to health benefit plans offered, renewed or extended on or after the effective date of this 2025 Act.
