House Bill 3134

Sponsored by Representative NOSSE, Senator PATTERSON; Representative PHAM H, Senator REYNOLDS (Pre-session 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 **as introduced.** The statement includes a measure digest written in compliance with applicable readability standards.

Digest: This Act tells insurers, PEBB, OEBB and CCOs to exempt some health care providers from prior authorization in some situations and makes rules about how to do so. Adds reporting rules for these insurers to DCBS and OHA. (Flesch Readability Score: 60.6).

Creates a process that exempts certain health care providers from prior authorization requirements under certain circumstances. Requires additional reporting to the Department of Consumer and Business Services and tells the department to make certain data publicly available. Applies these requirements to commercial health insurance, the Public Employees' Benefit Board, the Oregon Educators Benefit Board and coordinated care organizations.

A BILL FOR AN ACT

Relating to prior authorization; creating new provisions; amending ORS 243.144, 243.877, 414.072, 677.085, 731.236, 743B.250, 743B.423 and 743B.450; and prescribing an effective date.

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) As used in this section, "prior authorization" has the meaning given that term in ORS 743B.001.

(2) An insurer shall exempt a health care provider from any requirement to obtain prior authorization for the reimbursement of a claim for a health care service covered under a policy or certificate of health insurance if the insurer has approved 80 percent of the provider's requests for prior authorization for the health care service during the previous 12-month period, whether in response to an initial request or as a result of an internal appeal or an external review. The insurer shall notify the health care provider in writing of the health care service to which the exemption applies and the duration of the exemption, which may be no less than 12 months.

(3) An insurer may not require a health care provider to apply for or otherwise request an exemption to qualify for the exemption under subsection (2) of this section. A health care provider is entitled to an internal appeal and an external review of an insurer's failure to provide an exemption.

(4) An insurer may review and reconsider an exemption granted under subsection (2) of this section no more than once in any 12-month period. An insurer may revoke an exemption granted under subsection (2) of this section or, after 12 months, discontinue the exemption only if the insurer:

(a) Determines that:

(A) During the previous three-month period 80 percent of a health care provider's claims for reimbursement of the service did not meet the insurer's criteria for prior authorization; 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) The last five of the health care provider's claims for reimbursement of the service did not meet insurer's criteria for prior authorization, if the health care provider filed five or fewer claims for reimbursement of the service during the previous three-month period;

(b) Notifies the health care provider of the determination under paragraph (a) of this subsection and provides to the health care provider all of the information relied upon by the insurer in making the determination; and

(c) Notifies the health care provider, in clear and understandable language, how to request an internal appeal and an external review of this determination.

(5) An insurer is responsible for the costs associated with an internal appeal or external review pursuant to this section.

(6) A determination to deny, revoke or discontinue an exemption under this section must be made or reviewed by an individual who is licensed in this state and authorized to provide the service within the scope of the provider's license.

(7) An exemption granted under this section remains in effect until the 30th day after the insurer notifies the health care provider of the determination to revoke the exemption or, if the health care provider appealed the decision, until the fifth day after the revocation is upheld on appeal.

(8) An insurer may not deny or reduce payment for a health care service exempted from prior authorization requirements under this section, including a service performed or supervised by a health care provider other than the provider who ordered the service, unless the provider who provides the service:

(a) Knowingly and materially misrepresented the health care service in the request for payment submitted to the insurer with the intent to deceive or obtain unlawful payment; or

(b) Failed to perform the health care service to meet professional standards.

SECTION 3. ORS 743B.250 is amended to read:

743B.250. All insurers offering a health benefit plan in this state shall:

(1) Provide to all enrollees directly or in the case of a group policy to the employer or other policyholder for distribution to enrollees, to all applicants, and to prospective applicants upon request, the following information:

(a) The insurer's written policy on the rights of enrollees, including the right:

(A) To participate in decision making regarding the enrollee's health care.

(B) To be treated with respect and with recognition of the enrollee's dignity and need for privacy.

(C) To have grievances handled in accordance with this section.

(D) To be provided with the information described in this section.

(b) An explanation of the procedures described in subsection (2) of this section for making coverage determinations and resolving grievances. The explanation must be culturally and linguistically appropriate, as prescribed by the Department of Consumer and Business Services by rule, and must include:

(A) The procedures for requesting an expedited response to an internal appeal under subsection (2)(d) of this section or for requesting an expedited external review of an adverse benefit determination;

(B) A statement that if an insurer does not comply with the decision of an independent review organization under ORS 743B.256, the enrollee may sue the insurer under ORS 743B.258;

(C) The procedure to obtain assistance available from the insurer, if any, and from the Depart-

ment of Consumer and Business Services in filing grievances; and

(D) A description of the process for filing a complaint with the department.

(c) A summary of benefits and an explanation of coverage in a form and manner prescribed by the department by rule.

(d) A summary of the insurer's policies on prescription drugs, including:

(A) Cost-sharing differentials;

(B) Restrictions on coverage;

(C) Prescription drug formularies;

(D) Procedures by which a provider with prescribing authority may prescribe clinically appropriate drugs not included on the formulary;

(E) Procedures for the coverage of clinically appropriate prescription drugs not included on the formulary; and

(F) A summary of the criteria for determining whether a drug is experimental or investigational.

(e) A list of network providers and how the enrollee can obtain current information about the availability of providers and how to access and schedule services with providers, including clinic and hospital networks. The list must be available online and upon request in printed format.

(f) Notice of the enrollee's right to select a primary care provider and specialty care providers.

(g) How to obtain referrals for specialty care in accordance with ORS 743B.227.

(h) Restrictions on services obtained outside of the insurer's network or service area.

(i) The availability of continuity of care as required by ORS 743B.225.

(j) Procedures for accessing after-hours care and emergency services as required by ORS 743A.012.

(k) Cost-sharing requirements and other charges to enrollees.

(L) Procedures, if any, for changing providers.

(m) Procedures, if any, by which enrollees may participate in the development of the insurer's corporate policies.

(n) A summary of how the insurer makes decisions regarding coverage and payment for treatment or services, including a general description of any prior authorization and utilization review requirements that affect coverage or payment.

(o) Disclosure of any risk-sharing arrangement the insurer has with physicians or other providers.

(p) A summary of the insurer's procedures for protecting the confidentiality of medical records and other enrollee information and the requirement under ORS 743B.555 that a carrier or third party administrator send communications containing protected health information only to the enrollee who is the subject of the protected health information.

(q) An explanation of assistance provided to non-English-speaking enrollees.

(r) Notice of the information available from the department that is filed by insurers as required under ORS 743B.200, 743B.202 and 743B.423.

(2) Establish procedures, in accordance with requirements adopted by the department, for making coverage determinations and resolving grievances that provide for all of the following:

(a) Timely notice of adverse benefit determinations.

(b) A method for recording all grievances, including the nature of the grievance and significant action taken.

(c) Written decisions.

(d) An expedited response to a request for an internal appeal that accommodates the clinical

urgency of the situation.

(e) At least one but not more than two levels of internal appeal for group health benefit plans and one level of internal appeal for individual health benefit plans and for any denial of an exception to a prescription drug formulary. If an insurer provides:

(A) Two levels of internal appeal, a person who was involved in the consideration of the initial denial or the first level of internal appeal may not be involved in the second level of internal appeal; and

(B) No more than one level of internal appeal, a person who was involved in the consideration of the initial denial may not be involved in the internal appeal.

(f)(A) An external review that meets the requirements of ORS 743B.252, 743B.254 and 743B.255, after the enrollee has exhausted internal appeals or after the enrollee has been deemed to have exhausted internal appeals.

(B) An enrollee shall be deemed to have exhausted internal appeals if an insurer fails to strictly comply with this section and federal requirements for internal appeals.

(g) The opportunity for the enrollee to receive continued coverage of an approved and ongoing course of treatment under the health benefit plan pending the conclusion of the internal appeal process.

(h) The opportunity for the enrollee or any authorized representative chosen by the enrollee to:

(A) Submit for consideration by the insurer any written comments, documents, records and other materials relating to the adverse benefit determination; and

(B) Receive from the insurer, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the adverse benefit determination.

(3) Establish procedures for notifying affected enrollees of:

(a) A change in or termination of any benefit; and

(b)(A) The termination of a primary care delivery office or site; and

(B) Assistance available to enrollees in selecting a new primary care delivery office or site.

(4) Provide the information described in subsection (2) of this section and ORS 743B.254 at each level of internal appeal to an enrollee who is notified of an adverse benefit determination or to an enrollee who files a grievance.

(5) Upon the request of an enrollee, applicant or prospective applicant, provide:

(a) The insurer's annual report on grievances and internal appeals submitted to the department under subsection (8) of this section.

(b) A description of the insurer's efforts, if any, to monitor and improve the quality of health services.

(c) Information about the insurer's procedures for credentialing network providers.

(6) In addition to the requirements in ORS 743B.423 and 743B.602, provide, upon the request of an enrollee, a written summary of information that the insurer may consider in its utilization review of a particular condition or disease, to the extent the insurer maintains such criteria. This subsection does not require an insurer to advise an enrollee how the insurer would cover or treat that particular enrollee's disease or condition. Utilization review criteria that are proprietary shall be subject to oral disclosure only.

(7) Maintain for a period of at least six years written records that document all grievances described in ORS 743B.001 (8)(a) and make the written records available for examination by the department or by an enrollee or authorized representative of an enrollee with respect to a grievance made by the enrollee. The written records must include but are not limited to the following:

(a) Notices and claims associated with each grievance.

(b) A general description of the reason for the grievance.

(c) The date the grievance was received by the insurer.

(d) The date of the internal appeal or the date of any internal appeal meeting held concerning the appeal.

(e) The result of the internal appeal at each level of appeal.

(f) The name of the covered person for whom the grievance was submitted.

(8) Provide to the department, in the format prescribed by the department, an annual summary of the insurer's aggregate data regarding:

(a) Grievances;

(b) Internal appeals;

(c) Requests for external review; [*and*]

(d) The following information about requests for prior authorization received by the insurer:

(A) The number of requests received **and the number of days it took to approve or deny the request**;

(B) The number of requests that were initially denied and the reasons for the denials, including, but not limited to, lack of medical necessity or failure to provide additional clinical information requested by the insurer;

(C) The number of requests that were initially approved; and

(D) The number of denials that were reversed by internal appeals or external reviews[.]**;**

(e) The number of appeals from the revocation or denial of a prior authorization exemption as described in section 2 of this 2025 Act;

(f) The number of appeals from the revocation, denial or discontinuation of prior authorization exemptions, as described in section 2 of this 2025 Act, that were granted; and

(g) The time between an appeal from a revocation or denial of a prior authorization exemption, as described in section 2 of this 2025 Act, and the approval or denial of the appeal.

(9) Allow the exercise of any rights described in this section or ORS 743B.252 or 743B.255 by an authorized representative.

(10) Procedures adopted under subsection (2) of this section for health benefit plans other than grandfathered health plans must be consistent with 42 U.S.C. 300-gg-19 and rules adopted by the United States Department of Health and Human Services implementing 42 U.S.C. 300-gg-19.

(11) An adverse benefit determination under subsection (2)(a) of this section that is provided to an enrollee in a health benefit plan other than a grandfathered health plan must:

(a) Be provided in a culturally and linguistically appropriate manner;

(b) Be consistent with federal requirements regarding the manner and content for notices of benefit determinations and federal requirements for the full and fair review of adverse benefit determinations; and

(c) Include the information required by subsection (4) of this section and:

(A) Information sufficient to identify the claim involved, the date of services, the health care provider and, if applicable, the claim amount;

(B) A statement describing the availability, upon request, of the information described in subsection (12) of this section;

(C) The specific reason for the adverse benefit determination, a reference to the specific plan provisions on which the determination is based, the denial code and the meaning of the denial code and a description of the standard that was used to make the determination, if any;

(D) A description of available internal appeals and external reviews, including expedited appeals and reviews, and instructions on how to initiate an appeal or review; and

(E) Contact information for the office of consumer assistance within the Department of Consumer and Business Services.

(12) Upon the request of an enrollee, an insurer that makes an adverse benefit determination with respect to the enrollee under a health benefit plan other than a grandfathered health plan must provide the enrollee with the diagnosis code, the meaning of the diagnosis code, the treatment code and the meaning of the treatment code that are associated with the adverse benefit determination.

(13) An adverse benefit determination issued to an enrollee following the final level of internal appeals by an insurer under a health benefit plan other than a grandfathered health plan must, in addition to the requirements under subsection (11) of this section, include:

(a) An explanation and discussion of the decision to uphold the initial adverse benefit determination; and

(b) An authorization form, or other document that complies with state and federal privacy laws and is approved by the department, with which an enrollee that requests an external review under ORS 743B.255 may authorize the insurer and the enrollee's treating health care provider to disclose medical records or other protected health information pertinent to the external review.

(14) The department shall compile and make publicly available the information described in subsection (8) of this section.

SECTION 4. ORS 743B.450 is amended to read:

743B.450. (1) Except as provided in this subsection, when a claim under a health benefit plan is submitted to an insurer by a provider on behalf of an enrollee, the insurer shall pay a clean claim or deny the claim not later than 30 days after the date on which the insurer receives the claim. If an insurer requires additional information before payment of a claim, not later than 30 days after the date on which the insurer receives the claim, the insurer shall notify the enrollee and the provider in writing and give the enrollee and the provider an explanation of the additional information needed to process the claim. The insurer shall pay a clean claim or deny the claim not later than 30 days after the date on which the insurer receives the additional information.

(2) A contract between an insurer and a provider may not include a provision governing payment of claims that limits the rights and remedies available to a provider under this section and ORS 743B.452 or has the effect of relieving either party of its obligations under this section and ORS 743B.452.

(3) An insurer may pay a claim using a credit card or electronic funds transfer payment method that imposes on the provider a fee or similar charge to process the payment if:

(a) The insurer notifies the provider, in advance, of the fee or other charges associated with the use of the credit card or electronic funds transfer payment method;

(b) The insurer offers the provider an alternative payment method that does not impose fees or similar charges on the provider; and

(c) The provider or a designee of the provider elects to accept a payment of the claim using the payment method.

(4) An insurer shall establish a method of communicating to providers the procedures and information necessary to complete claim forms. The procedures and information must be reasonably accessible to providers.

(5) This section does not create an assignment of payment to a provider.

(6) Each insurer shall report to the Director of the Department of Consumer and Business Ser-

vices on its compliance under this section according to requirements established by the director.

(7) The director shall adopt by rule a definition of "clean claim" and shall consider the definition of "clean claim" used by the federal Department of Health and Human Services for the payment of Medicare claims.

(8) The Department of Consumer and Business Services shall compile and make publicly available the information described in subsection (6) of this section.

SECTION 5. ORS 731.236 is amended to read:

731.236. (1) The Director of the Department of Consumer and Business Services shall enforce the provisions of the Insurance Code for the public good, and shall execute the duties imposed by the code.

(2) The director has the powers and authority expressly conferred by or reasonably implied from the provisions of the Insurance Code.

(3) The director may conduct such examinations and investigations of insurance matters, in addition to examinations and investigations expressly authorized, as the director considers proper to determine whether any person has violated any provision of the Insurance Code or to secure information useful in the lawful administration of any such provision. The cost of such additional examinations and investigations shall be borne by the state.

(4) The director may enforce the adjudication of health insurance benefits and claims in this state by actions including but not limited to examining and investigating health insurance matters:

(a) Brought forward by assignees of insurance benefit rights who file claims with insurers operating within this state; and

(b) Arising out of the claims administration activities of health care clearinghouses operating within this state.

[*(4)*] **(5)** The director has such additional powers and duties as may be provided by other laws of this state.

SECTION 6. ORS 677.085, as amended by section 122, chapter 73, Oregon Laws 2024, is amended to read:

677.085. A person is practicing medicine if the person does one or more of the following:

(1) Advertise, hold out to the public or represent in any manner that the person is authorized to practice medicine in this state.

(2) For compensation directly or indirectly received or to be received, offer or undertake to prescribe, give or administer any drug or medicine for the use of any other person.

(3) Offer or undertake to perform any surgical operation upon any person.

(4) Offer or undertake to diagnose, cure or treat in any manner, or by any means, methods, devices or instrumentalities, any disease, illness, pain, wound, fracture, infirmity, deformity, defect or abnormal physical or mental condition of any person.

(5) Except as provided in ORS 677.060, append the letters "M.D.," "D.O." or "P.A." to the person's name, or use the words "Doctor," "Physician," "Surgeon," "Physician Associate," or any abbreviation or combination thereof, or any letters or words of similar import in connection with the person's name, or any trade name in which the person is interested, in the conduct of any occupation or profession pertaining to the diagnosis or treatment of human diseases or conditions mentioned in this section.

(6) Render a determination of medical necessity or a decision affecting the diagnosis or treatment of a patient, including but not limited to participating in a utilization review on

behalf of an insurer.

SECTION 7. ORS 743B.423 is amended to read:

743B.423. (1) All insurers offering a health benefit plan in this state that provide utilization review or have utilization review provided on their behalf shall file an annual summary with the Department of Consumer and Business Services that describes all utilization review policies, including delegated utilization review functions, and documents the insurer's procedures for monitoring of utilization review activities.

(2) All utilization review activities conducted pursuant to subsection (1) of this section shall comply with the following:

(a) In addition to the requirements of ORS 743B.602, in establishing utilization review, the insurer must use clinical review criteria that are evidence-based and continuously updated based on new evidence and research, and take into account new developments in treatment.

(b) The insurer must adjudicate claims for reimbursement in accordance with ORS 743B.450 based on the information submitted by the provider and may not require the provider to resubmit the information.

(c) The criteria and the process used in the utilization review and the method of development of the criteria must be made available for review to contracting providers.

(d) The insurer must have a website where:

(A) The following information is clearly posted:

(i) All requirements for requesting coverage of a treatment, drug, device or diagnostic or laboratory test that is subject to utilization review, including the specific documentation required for a request to be considered complete.

(ii) A list of the specific treatments, drugs, devices or diagnostic or laboratory tests that are subject to utilization review.

(B) A provider can make a secure electronic submission, meeting industry standards for privacy, of a request for coverage of a treatment, drug, device or diagnostic or laboratory test that is subject to utilization review, along with needed forms and documents, and receive an electronic acknowledgement of receipt of the request.

(e) If the insurer deems as incomplete a request made for coverage of a treatment, drug, device or diagnostic or laboratory test that is subject to utilization review, the insurer must inform the provider of the specific information needed for the request to be considered complete.

(f) The insurer must use a physician licensed under ORS 677.100 to 677.228 to make all final recommendations regarding coverage of a treatment, drug, device or diagnostic or laboratory test that is subject to utilization review and to consult as needed.

(g) The insurer must give a provider notice in writing of a denial of a request for coverage of a treatment, drug, device or diagnostic or laboratory test that is subject to utilization review. The notice must be written in plain language, be understandable to providers and patients, and include the specific reason for the denial based on evidence-based, peer-reviewed literature. If the denial is based on terms in a policy or certificate of insurance, the denial must cite the specific language in the policy or certificate.

(h) The insurer must make available to any provider who has had a request for treatment or payment for services denied as not medically necessary or as experimental shall be provided an opportunity for a timely appeal before an appropriate medical consultant or peer review committee.

(i) Except as provided in paragraph (j) of this subsection, an insurer must issue a determination on a provider's or an enrollee's request for coverage of a nonemergency treatment, drug, device or

diagnostic or laboratory test that is subject to utilization review within a reasonable period of time appropriate to the medical circumstances but no later than two business days after receipt of the request, and qualified health care personnel must be available for same-day telephone responses to inquiries concerning certification of continued length of stay.

(j) If the insurer requires additional information from an enrollee or a provider to make a determination on a request for coverage of a treatment, drug, device or diagnostic or laboratory test that is subject to utilization review, no later than two business days after receipt of the request, the insurer shall notify the enrollee and the provider in writing of the additional information needed to make the determination. The insurer shall issue the determination by the later of:

(A) Two business days after receipt of a response from the provider or enrollee to the request for additional information; or

(B) Fifteen days after the date of the request for additional information.

(k) If a change in a drug formulary or other change in coverage impacts the coverage of any enrollee's treatment plan and the enrollee has been stabilized on the treatment plan for at least 90 days, the insurer must continue to provide coverage of the treatment until utilization review and all internal appeals and external reviews are completed.

(L) The insurer may not alter utilization review requirements, or initiate or implement new utilization review requirements, without giving a 60-day advance notice to all participating providers.

(m) In addition to the requirements of ORS 743B.420, an approved request for coverage of a treatment, other than a prescription drug, shall be binding on the insurer for a period ending on the later of the following:

(A) The reasonable duration of the treatment based on clinical standards; or

(B) [*Sixty days*] **Twelve months** after the date that the treatment begins following approval of prior authorization.

(n) Except as provided in paragraph (o) of this subsection, an approved request for coverage of a prescription drug shall be binding on the insurer for one year from the date that the treatment begins following approval of the request [*if the drug:*]

[*(A) Is prescribed as a maintenance therapy that is expected to last at least 12 months based on medical or scientific evidence;*]

[*(B) Continues to be prescribed throughout the 12-month period; and*]

[*(C)(i) Is prescribed for a condition that is within the scope of use for the drug as approved by the United States Food and Drug Administration; or*]

[*(ii) Has been proven to be a safe and effective form of treatment for the enrollee's medical condition based on clinical practice guidelines developed from peer-reviewed medical literature*].

(o) Paragraph (n) of this subsection does not apply if:

(A) A therapeutic equivalent of the prescription drug or a generic alternative to the prescription drug is or becomes available as a substitute for the drug for which prior authorization is requested or was approved; or

(B) A biologic product is or becomes available that is determined by the United States Food and Drug Administration to be interchangeable with the drug for which prior authorization is requested or approved.

(p) Notwithstanding paragraphs (m), (n) and (o) of this subsection, an approved request for coverage for a prescription drug or treatment of a degenerative disease or condition shall be binding on the insurer until either the disease or condition is cured or the death of the

patient occurs.

[*(p)*] **(q)** Paragraphs (k), (m) and (n) of this subsection do not require an insurer to reimburse the cost of care for a patient who is no longer enrolled in the health benefit plan offered by the insurer.

SECTION 8. ORS 243.144, as amended by section 9, chapter 17, Oregon Laws 2024, is amended to read:

243.144. Benefit plans offered by the Public Employees' Benefit Board that reimburse the cost of medical and other health services and supplies must comply with the requirements for health benefit plan coverage described in:

(1) ORS 743A.058;

(2) ORS 743A.140;

(3) ORS 743A.141;

(4) ORS 743B.256;

(5) ORS 743B.287 (4);

(6) ORS 743B.420;

(7) ORS 743B.423;

(8) ORS 743B.601;

(9) ORS 743B.602;

[*(9)*] **(10)** ORS 743B.810;

[*(10)*] **(11)** ORS 743A.325; [*and*]

[*(11)*] **(12)** ORS 743A.051 (2)(c)[.]**;**

(13) 743B.250; and

(14) Section 2 of this 2025 Act.

SECTION 9. ORS 243.144, as amended by sections 9 and 10, chapter 17, Oregon Laws 2024, is amended to read:

243.144. Benefit plans offered by the Public Employees' Benefit Board that reimburse the cost of medical and other health services and supplies must comply with the requirements for health benefit plan coverage described in:

(1) ORS 743A.058;

(2) ORS 743A.140;

(3) ORS 743A.141;

(4) ORS 743B.256;

(5) ORS 743B.287 (4);

(6) ORS 743B.420;

(7) ORS 743B.423;

(8) ORS 743B.601;

(9) ORS 743B.602;

[*(9)*] **(10)** ORS 743B.810; [*and*]

[*(10)*] **(11)** ORS 743A.325[.]**;**

(12) ORS 743B.250; and

(13) Section 2 of this 2025 Act.

SECTION 10. ORS 243.877, as amended by section 11, chapter 17, Oregon Laws 2024, is amended to read:

243.877. Benefit plans offered by the Oregon Educators Benefit Board that reimburse the cost of medical and other health services and supplies must comply with the requirements for health benefit plan coverage described in:

(1) ORS 743A.058;

(2) ORS 743A.140;

(3) ORS 743A.141;

(4) ORS 743B.256;

(5) ORS 743B.287 (4);

(6) ORS 743B.420;

(7) ORS 743B.423;

(8) ORS 743B.601;

(9) ORS 743B.602;

[*(9)*] **(10)** ORS 743B.810;

[*(10)*] **(11)** ORS 743A.325; [*and*]

[*(11)*] **(12)** ORS 743A.051 (2)(c)[.]**;**

(13) ORS 743B.250; and

(14) Section 2 of this 2025 Act.

SECTION 11. ORS 243.877, as amended by sections 11 and 12, chapter 17, Oregon Laws 2024, is amended to read:

243.877. Benefit plans offered by the Oregon Educators Benefit Board that reimburse the cost of medical and other health services and supplies must comply with the requirements for health benefit plan coverage described in:

(1) ORS 743A.058;

(2) ORS 743A.140;

(3) ORS 743A.141;

(4) ORS 743B.256;

(5) ORS 743B.287 (4);

(6) ORS 743B.420;

(7) ORS 743B.423;

(8) ORS 743B.601;

(9) ORS 743B.602;

[*(9)*] **(10)** ORS 743B.810; [*and*]

[*(10)*] **(11)** ORS 743A.325[.]**;**

(12) ORS 743B.250; and

(13) Section 2 of this 2025 Act.

SECTION 12. ORS 414.072 is amended to read:

414.072. (1) As used in this section[*,*]**:**

(a) "Coordinated care organization" has the meaning given that term in ORS 414.025.

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

(2) The Oregon Health Authority shall compile and annually post to the authority's website a report of the following information, in the aggregate, that was reported to the authority by coordinated care organizations regarding requests for prior authorization received by coordinated care organizations or risk-bearing entities acting for or in concert with coordinated care organizations:

(a) The number of requests received;

(b) The number of requests that were initially denied and the reasons for the denials, including, but not limited to, lack of medical necessity or incomplete requests; [*and*]

(c) The number of denials that were reversed on an appeal[.]**; and**

(d) The number of days it took to approve or deny a request.

(3) Notwithstanding ORS 414.325, coordinated care organizations or risk-bearing entities acting for or in concert with coordinated care organizations shall comply with the prior authorization exemption requirements described in section 2 of this 2025 Act.

SECTION 13. This 2025 Act takes effect on the 91st day after the date on which the 2025 regular session of the Eighty-third Legislative Assembly adjourns sine die.
