HB 3134-4
(LC 3683)
4/22/25 (EKJ/ps)

Requested by Representative NOSSE

PROPOSED AMENDMENTS TO
HOUSE BILL 3134

On page 1 of the printed bill, line 2, after "provisions;" delete the rest of the line and line 3 and insert "and amending ORS 743B.250.".

Delete lines 5 through 27 and delete pages 2 through 12 and insert:

"SECTION 1. 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 Department 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**, which shall be published by the department, in a format that does identify the insurer, to the department's website no later than March 1 of each calendar year,** about requests for prior authorization received by the insurer:

"[*(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 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.*]

"**(A) The percentage and number of standard prior authorization requests that were approved;**

"(B) The percentage and number of standard prior authorization requests that were denied;

"(C) The percentage and number of standard prior authorization

requests that were approved after appeal;

"(D) The percentage and number of all prior authorization requests for which the time frame for review was extended and the request was approved;

"(E) The percentage and number of expedited prior authorization requests that were approved;

"(F) The percentage and number of expedited prior authorization requests that were denied;

"(G) The average and median times that elapsed between the submission of a request and a determination by the insurer for standard prior authorization; and

"(H) The average and median times that elapsed between the submission of a request and a decision by the insurer for expedited prior authorization.

"(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) As used in this section:**

"(a) 'Expedited prior authorization' means a prior authorization that must be expedited in order to avoid jeopardizing the enrollee's life, health or ability to maintain or regain maximum function.

"(b) 'Standard prior authorization' means a prior authorization request that is not an expedited prior authorization request.

"SECTION 2. An insurer offering a health benefit plan that requires prior authorization for surgical procedures may not require prior authorization for an additional or related health care procedure that is identified during the authorized surgical procedure if:

"(1) The provider, while providing an approved surgical procedure, identifies a medical condition, disease or ailment that was not identified in the prior authorization request and, in accordance with generally accepted standards of medical practice, determines that performing a related health care procedure, instead of or in addition to the approved surgical procedure, is medically necessary and, in the provider's judgment, to interrupt or delay the provision of care in order to obtain prior authorization for the additional or related health care procedure would not be medically advisable;

"(2) The additional or related health care procedure is a covered benefit under the enrollee's health benefit plan; and

"(3) The additional or related health care procedure is not experimental or for investigation purposes.

"SECTION 3. (1) All insurers offering a health benefit plan in this state that provides utilization review or has utilization review provided on their behalf shall utilize a prior authorization application programming interface as described in 45 C.F.R. 156.223(b) as in effect on February 28, 2024. The application programming interface shall enable a provider to:

"(a) Determine whether prior authorization is required;

"(b) Identify the information and documentation necessary to sub-

mit the request; and

"(c) Transfer prior authorization requests and determinations from the provider's electronic health records or practice management system through a secure electronic transmission.

"(2) An insurer shall respond through the application programming interface described in subsection (1) of this section to a request that was submitted by a provider through the application programming interface.

"SECTION 4. Sections 2 and 3 of this 2025 Act are added to and made a part of the Insurance Code.

"SECTION 5. Section 3 of this 2025 Act becomes operative on January 1, 2027.".
