FISCAL IMPACT OF PROPOSED LEGISLATION **Measure: SB 382 - A**

Seventy-Seventh Oregon Legislative Assembly – 2013 Regular Session
Legislative Fiscal Office

Only Impacts on Original or Engrossed Versions are Considered Official

Prepared by: Kim To
Reviewed by: Linda Ames, Susie Jordan
Date: 4/19/2013

Measure Description:
Directs Department of Consumer and Business Services and Oregon Health Authority to jointly develop form that providers in this state may use to request prior authorization for prescription drug benefits.

Government Unit(s) Affected:
Department of Consumer and Business Services (DCBS), Oregon Health Authority (OHA)

Local Government Mandate:
This bill does not affect local governments' service levels or shared revenues sufficient to trigger Section 15, Article XI of the Oregon Constitution.

Analysis:
Senate Bill 382 requires the Department of Consumer and Business Services, in consultation with the Oregon Health Authority, to develop by rule a form that providers in Oregon are required to use to request prior authorization for prescription drug benefit. The bill details the length and content of this form. The bill contains an emergency clause, and takes effect on passage.

Department of Consumer and Business Services (DCBS)
Passage of this bill is anticipated to have minimal fiscal impact for the Department of Consumer and Business Services. DCBS will use existing staff and resources to work with the Oregon Health Authority and to perform the rulemaking activities required by this bill.

Oregon Health Authority (OHA)
The fiscal impact of this bill on the Oregon Health Authority is indeterminate. Although OHA anticipates using existing staff and resources to consult with DCBS in developing rules the form, the agency states that the new form will require modifications to the MMIS system. However, because the form is not yet developed, OHA cannot predict the scope of change that will be needed.

Furthermore, OHA is concerned that certain requirements for the form specified in this bill might result in a fiscal impact for its Medical Assistance Programs (MAP). The bill limits the form to two pages which limits the amount of information a payer/insurer can request. OHA reports that in some cases there may be additional information that is required to appropriately ensure safe and appropriate therapy. If the Medical Assistance Programs and coordinated care organizations are limited in the information they can request, this process could potentially expose clients to harm that could result in collateral health care costs, and the clients could end up receiving medication that is unnecessary or inappropriate.

77th OREGON LEGISLATIVE ASSEMBLY – 2013 Regular Session **MEASURE: SB 382 A**
STAFF MEASURE SUMMARY **CARRIER: Sen. Bates**
Senate Committee on Health Care & Human Services

REVENUE: No revenue impact
FISCAL: Fiscal statement issued

Action:		Do Pass as Amended and Be Printed Engrossed
Vote:		4 - 0 - 1
	Yeas:	Knopp, Kruse, Shields, Monnes Anderson
	Nays:	0
	Exc.:	Steiner Hayward
Prepared By:		Sandy Thiele-Cirka, Administrator
Meeting Dates:		4/9, 4/16

WHAT THE MEASURE DOES: Directs Department of Consumer and Business Services (DCBS) and Oregon Health Authority (OHA) jointly develop form that health care providers in Oregon must use to request prior authorization for prescription benefits. Requires health care providers and all health benefit plan insurers, public and private, use form. Adds requirement that form include space for additional necessary information. Operative date of July 1, 2015. Declares emergency, effective on passage.

ISSUES DISCUSSED:
- Different form for each insurance company
- Need for system efficiency
- Complexities of non-uniform system
- Requirement for providers to use standardized form
- Prescription authorization complexities
- Proposed amendment

EFFECT OF COMMITTEE AMENDMENT: Replaces the measure.

BACKGROUND: Currently, insurance providers require prior authorization forms for certain medications. Often, the providers will have different forms for different medications; additionally, different insurance providers have different forms. The result is that providers generally have dedicated staff to determine the appropriate prior authorization form to use for any given insurance company. Recently a number of insurance providers in Oregon have voluntarily reduced the number of prior authorization forms they require from providers; however there are still insurance providers that have multiple forms.

Senate Bill 382-A simplifies the form to a uniform design and length to reduce the administrative costs associated with prescribing medications that require prior authorization from insurance providers.

A-Engrossed
Senate Bill 382

Ordered by the Senate May 2
Including Senate Amendments dated May 2

Sponsored by Senator BATES (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.

Directs Department of Consumer and Business Services and Oregon Health Authority to jointly develop form that providers in this state may use to request prior authorization for prescription drug benefits. [*Requires response to request for such prior authorization within two business days of receiving request.*] **Provides that person that requires prior authorization for prescription drugs must accept form.**

[*Applies to insurers on July 1, 2014.*]

[*Applies to health benefit plans*] **Becomes operative** on July 1, 2015.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to prior authorization for prescription drugs; creating new provisions; amending ORS 743.801; and declaring an emergency.

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

SECTION 1. (1) The Department of Consumer and Business Services, in consultation with the Oregon Health Authority, shall develop by rule a form that providers in this state shall use to request prior authorization for prescription drug benefits. The form must:

(a) Be uniform for all providers;

(b) Not exceed two pages;

(c) Be electronically available and transmissible; and

(d) Include a provision under which providers may request additional information.

(2) If a person described in ORS 743.061 (2) requires prior authorization for prescription drug benefits, the person must accept the form developed under subsection (1) of this section.

(3) An insurer meets the requirement set forth in ORS 743.807 (2)(d) if the insurer answers a provider's request for prior authorization within two business days of having received a completed form developed under subsection (1) of this section.

(4) The department may adopt rules to implement this section.

SECTION 2. ORS 743.801, as amended by section 5, chapter 24, Oregon Laws 2012, is amended to read:

743.801. As used in this section and ORS 743.803, 743.804, 743.806, 743.807, 743.808, 743.811, 743.814, 743.817, 743.819, 743.821, 743.823, 743.827, 743.829, 743.831, 743.834, 743.837, 743.839, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.894, 743.911, 743.912, 743.913, 743.917 and 743.918 **and section 1 of this 2013 Act**:

(1) "Adverse benefit determination" means an insurer's denial, reduction or termination of a

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.

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 743.730, 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; or

(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 743.854.

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

(3) "Enrollee" has the meaning given that term in ORS 743.730.

(4) "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 743.804 (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.

(5) "Health benefit plan" has the meaning given that term in ORS 743.730.

(6) "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 743.522, to provide health care services to group members.

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

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

(9) "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.

(10) "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.

(11)(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.

(12) "Prior authorization" means a determination by an insurer prior to provision of services that the insurer will provide reimbursement for the services. "Prior authorization" does not include referral approval for evaluation and management services between providers.

(13) "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.

(14) "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 services, procedures or settings.

SECTION 3. (1) Section 1 of this 2013 Act and the amendments to ORS 743.801 by section 2 of this 2013 Act become operative on July 1, 2015.

(2) The Department of Consumer and Business Services and the Oregon Health Authority may take any action before the operative date specified in subsection (1) of this section that is necessary to enable the department and the authority to exercise, on and after the operative date specified in subsection (1) of this section, all the duties, functions and powers conferred on the department and the authority by section 1 of this 2013 Act and the amendments to ORS 743.801 by section 2 of this 2013 Act.

SECTION 4. This 2013 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2013 Act takes effect on its passage.