

B-Engrossed
Senate Bill 382

Ordered by the Senate June 14
Including Senate Amendments dated May 2 and June 14

Sponsored by Senator BATES (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.

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. Provides that person that requires prior authorization for prescription drugs must *[accept]* **allow use of form.**

Becomes operative on July 1, 2015.

Declares emergency, effective on passage.

A BILL FOR AN ACT

1
2 Relating to prior authorization for prescription drugs; creating new provisions; amending ORS
3 743.801; and declaring an emergency.

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

5 **SECTION 1. Section 2 of this 2013 Act is added to and made a part of the Insurance Code.**

6 **SECTION 2. (1) The Department of Consumer and Business Services, in consultation with**
7 **the Oregon Health Authority, shall develop by rule a form that providers in this state shall**
8 **use to request prior authorization for prescription drug benefits. The form must:**

9 (a) **Be uniform for all providers;**

10 (b) **Not exceed two pages;**

11 (c) **Be electronically available and transmissible; and**

12 (d) **Include a provision under which additional information may be requested and pro-**
13 **vided.**

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

17 (3) **An insurer meets the requirement set forth in ORS 743.807 (2)(d) if the insurer an-**
18 **swers a provider's request for prior authorization within two business days of having re-**
19 **ceived a completed form developed under subsection (1) of this section and all supporting**
20 **documentation needed to process the request.**

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

22 **SECTION 3. ORS 743.801, as amended by section 5, chapter 24, Oregon Laws 2012, is amended**
23 **to read:**

24 743.801. As used in this section and ORS 743.803, 743.804, 743.806, 743.807, 743.808, 743.811,
25 743.814, 743.817, 743.819, 743.821, 743.823, 743.827, 743.829, 743.831, 743.834, 743.837, 743.839, 743.854,
26 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.894, 743.911, 743.912, 743.913,

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.

1 743.917 and 743.918 **and section 2 of this 2013 Act:**

2 (1) "Adverse benefit determination" means an insurer's denial, reduction or termination of a
3 health care item or service, or an insurer's failure or refusal to provide or to make a payment in
4 whole or in part for a health care item or service, that is based on the insurer's:

5 (a) Denial of eligibility for or termination of enrollment in a health benefit plan;

6 (b) Rescission or cancellation of a policy or certificate;

7 (c) Imposition of a preexisting condition exclusion as defined in ORS 743.730, source-of-injury
8 exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or
9 services;

10 (d) Determination that a health care item or service is experimental, investigational or not
11 medically necessary, effective or appropriate; or

12 (e) Determination that a course or plan of treatment that an enrollee is undergoing is an active
13 course of treatment for purposes of continuity of care under ORS 743.854.

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

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

17 (4) "Grievance" means:

18 (a) A communication from an enrollee or an authorized representative of an enrollee expressing
19 dissatisfaction with an adverse benefit determination, without specifically declining any right to
20 appeal or review, that is:

21 (A) In writing, for an internal appeal or an external review; or

22 (B) In writing or orally, for an expedited response described in ORS 743.804 (2)(d) or an expedited
23 external review; or

24 (b) A written complaint submitted by an enrollee or an authorized representative of an enrollee
25 regarding the:

26 (A) Availability, delivery or quality of a health care service;

27 (B) Claims payment, handling or reimbursement for health care services and, unless the enrollee
28 has not submitted a request for an internal appeal, the complaint is not disputing an adverse benefit
29 determination; or

30 (C) Matters pertaining to the contractual relationship between an enrollee and an insurer.

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

32 (6) "Independent practice association" means a corporation wholly owned by providers, or whose
33 membership consists entirely of providers, formed for the sole purpose of contracting with insurers
34 for the provision of health care services to enrollees, or with employers for the provision of health
35 care services to employees, or with a group, as described in ORS 743.522, to provide health care
36 services to group members.

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

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

40 (9) "Managed health insurance" means any health benefit plan that:

41 (a) Requires an enrollee to use a specified network or networks of providers managed, owned,
42 under contract with or employed by the insurer in order to receive benefits under the plan, except
43 for emergency or other specified limited service; or

44 (b) In addition to the requirements of paragraph (a) of this subsection, offers a point-of-service
45 provision that allows an enrollee to use providers outside of the specified network or networks at

1 the option of the enrollee and receive a reduced level of benefits.

2 (10) "Medical services contract" means a contract between an insurer and an independent
3 practice association, between an insurer and a provider, between an independent practice associ-
4 ation and a provider or organization of providers, between medical or mental health clinics, and
5 between a medical or mental health clinic and a provider to provide medical or mental health ser-
6 vices. "Medical services contract" does not include a contract of employment or a contract creating
7 legal entities and ownership thereof that are authorized under ORS chapter 58, 60 or 70, or other
8 similar professional organizations permitted by statute.

9 (11)(a) "Preferred provider organization insurance" means any health benefit plan that:

10 (A) Specifies a preferred network of providers managed, owned or under contract with or em-
11 ployed by an insurer;

12 (B) Does not require an enrollee to use the preferred network of providers in order to receive
13 benefits under the plan; and

14 (C) Creates financial incentives for an enrollee to use the preferred network of providers by
15 providing an increased level of benefits.

16 (b) "Preferred provider organization insurance" does not mean a health benefit plan that has
17 as its sole financial incentive a hold harmless provision under which providers in the preferred
18 network agree to accept as payment in full the maximum allowable amounts that are specified in
19 the medical services contracts.

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

23 (13) "Provider" means a person licensed, certified or otherwise authorized or permitted by laws
24 of this state to administer medical or mental health services in the ordinary course of business or
25 practice of a profession.

26 (14) "Utilization review" means a set of formal techniques used by an insurer or delegated by
27 the insurer designed to monitor the use of or evaluate the medical necessity, appropriateness, effi-
28 cacy or efficiency of health care services, procedures or settings.

29 **SECTION 4. (1) Section 2 of this 2013 Act and the amendments to ORS 743.801 by section**
30 **3 of this 2013 Act become operative on July 1, 2015.**

31 **(2) The Department of Consumer and Business Services and the Oregon Health Authority**
32 **may take any action before the operative date specified in subsection (1) of this section that**
33 **is necessary to enable the department and the authority to exercise, on and after the oper-**
34 **ative date specified in subsection (1) of this section, all the duties, functions and powers**
35 **conferred on the department and the authority by section 2 of this 2013 Act and the**
36 **amendments to ORS 743.801 by section 3 of this 2013 Act.**

37 **SECTION 5. This 2013 Act being necessary for the immediate preservation of the public**
38 **peace, health and safety, an emergency is declared to exist, and this 2013 Act takes effect**
39 **on its passage.**

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