SB 382-2
(LC 1602)
4/15/13 (MBM/ps)

PROPOSED AMENDMENTS TO
SENATE BILL 382

On page 1 of the printed bill, delete lines 5 through 28 and delete pages 2 through 4 and insert:

"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 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 rep-

resentative 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.".