

Senate Bill 1539

Sponsored by Senator WINTERS (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**.

Imposes requirements on step therapy drug protocols required by specified persons that pay for or reimburse claims for prescription drugs.

A BILL FOR AN ACT

1
2 Relating to prescription drug coverage; creating new provisions; and amending ORS 414.337 and
3 414.653 and section 64, chapter 602, Oregon Laws 2011.

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

5 **SECTION 1. Section 2 of this 2014 Act is added to and made a part of the Insurance Code.**

6 **SECTION 2. (1) As used in this section:**

7 (a) **"Health care coverage plan" includes:**

8 (A) **A health benefit plan, as defined in ORS 743.730;**

9 (B) **An insurance policy or certificate covering the cost of prescription drugs, hospital
10 expenses, health care services and medical expenses, equipment and supplies;**

11 (C) **A medical services contract, as defined in ORS 743.801;**

12 (D) **A multiple employer welfare arrangement, as defined in ORS 750.301;**

13 (E) **A contract or agreement with a health care service contractor, as defined in ORS
14 750.005, or a preferred provider organization;**

15 (F) **A pharmacy benefit manager, as defined in ORS 735.530, or other third party admin-
16 istrator that pays prescription drug claims;**

17 (G) **A coordinated care organization, as defined in ORS 414.025;**

18 (H) **A prepaid managed care health services organization, as defined in ORS 414.736; and**

19 (I) **An accident insurance policy or any other insurance contract providing reimburse-
20 ment for the cost of prescription drugs, hospital expenses, health care services and medical
21 expenses, equipment and supplies.**

22 (b) **"Step therapy" means a type of drug protocol in which a health care coverage plan
23 will not cover a prescribed drug unless the patient has first tried a drug or series of drugs
24 specified by the health care coverage plan.**

25 (2) **A health care coverage plan that provides prescription drug coverage and that con-
26 trols utilization of prescription drugs using step therapy shall provide a clear and convenient
27 process for a prescribing practitioner to expeditiously obtain an override of the protocol if
28 the prescribing practitioner demonstrates, based on sound clinical evidence, that the treat-
29 ment required under the protocol:**

30 (a) **Has been ineffective in the treatment of the disease or medical condition of the pa-
31 tient for whom the override is requested;**

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 (b) Is reasonably expected to be ineffective based on the known relevant physical or
 2 mental characteristics and medical history of the patient and the known characteristics of
 3 the drug regimen; or

4 (c) Will cause or is likely to cause an adverse reaction or physical harm to the patient.

5 (3) The duration of step therapy required by a health care coverage plan may not exceed
 6 the longer of:

7 (a) The period deemed necessary by the prescribing practitioner to determine the
 8 treatment's clinical effectiveness; and

9 (b) A period of 30 days.

10 **SECTION 3.** ORS 414.337 is amended to read:

11 414.337. (1) The Oregon Health Authority may not *[adopt or amend any rule that requires]* **re-**
 12 **quire** a prescribing practitioner to contact the authority to request an exception for a medically
 13 appropriate or medically necessary drug that is not listed on the Practitioner-Managed Prescription
 14 Drug Plan drug list for that class of drugs adopted under ORS 414.334, unless otherwise authorized
 15 by enabling legislation setting forth the requirement for prior authorization.

16 (2) **Any step therapy protocols required by the authority must comply with the require-**
 17 **ments for step therapy described in section 2 of this 2014 Act.**

18 **SECTION 4.** ORS 414.653 is amended to read:

19 414.653. (1) The Oregon Health Authority shall encourage coordinated care organizations to use
 20 alternative payment methodologies that:

21 (a) Reimburse providers on the basis of health outcomes and quality measures instead of the
 22 volume of care;

23 (b) Hold organizations and providers responsible for the efficient delivery of quality care;

24 (c) Reward good performance;

25 (d) Limit increases in medical costs; and

26 (e) Use payment structures that create incentives to:

27 (A) Promote prevention;

28 (B) Provide person centered care; and

29 (C) Reward comprehensive care coordination using delivery models such as patient centered
 30 primary care homes.

31 (2) The authority shall encourage coordinated care organizations to utilize alternative payment
 32 methodologies that move from a predominantly fee-for-service system to payment methods that base
 33 reimbursement on the quality rather than the quantity of services provided.

34 (3) The authority shall assist and support coordinated care organizations in identifying cost-
 35 cutting measures.

36 (4) If a service provided in a health care facility is not covered by Medicare because the service
 37 is related to a health care acquired condition, the cost of the service may not be:

38 (a) Charged by a health care facility or any health services provider employed by or with priv-
 39 ileges at the facility, to a coordinated care organization, a patient or a third-party payer; or

40 (b) Reimbursed by a coordinated care organization.

41 (5)(a) Notwithstanding subsections (1) and (2) of this section, until July 1, 2014, a coordinated
 42 care organization that contracts with a Type A or Type B hospital or a rural critical access hospi-
 43 tal, as described in ORS 442.470, shall reimburse the hospital fully for the cost of covered services
 44 based on the cost-to-charge ratio used for each hospital in setting the global payments to the coor-
 45 dinated care organization for the contract period.

1 (b) The authority shall base the global payments to coordinated care organizations that contract
 2 with rural hospitals described in this section on the most recent audited Medicare cost report for
 3 Oregon hospitals adjusted to reflect the Medicaid mix of services.

4 (c) The authority shall identify any rural hospital that would not be expected to remain finan-
 5 cially viable if paid in a manner other than as prescribed in paragraphs (a) and (b) of this subsection
 6 based upon an evaluation by an actuary retained by the authority. On and after July 1, 2014, the
 7 authority may, on a case-by-case basis, require a coordinated care organization to continue to re-
 8 imburse a rural hospital determined to be at financial risk, in the manner prescribed in paragraphs
 9 (a) and (b) of this subsection.

10 (d) This subsection does not prohibit a coordinated care organization and a hospital from mu-
 11 tually agreeing to reimbursement other than the reimbursement specified in paragraph (a) of this
 12 subsection.

13 (e) Hospitals reimbursed under paragraphs (a) and (b) of this subsection are not entitled to any
 14 additional reimbursement for services provided.

15 (6) Notwithstanding subsections (1) and (2) of this section, coordinated care organizations must
 16 comply with federal requirements for payments to providers of Indian health services, including but
 17 not limited to the requirements of 42 U.S.C. 1396j and 42 U.S.C. 1396u-2(a)(2)(C).

18 **(7) Any step therapy protocols required by a coordinated care organization must comply**
 19 **with the requirements for step therapy described in section 2 of this 2014 Act.**

20 **SECTION 5.** Section 2 of this 2014 Act is amended to read:

21 **Sec. 2.** (1) As used in this section:

22 (a) "Health care coverage plan" includes:

23 (A) A health benefit plan, as defined in ORS 743.730;

24 (B) An insurance policy or certificate covering the cost of prescription drugs, hospital expenses,
 25 health care services and medical expenses, equipment and supplies;

26 (C) A medical services contract, as defined in ORS 743.801;

27 (D) A multiple employer welfare arrangement, as defined in ORS 750.301;

28 (E) A contract or agreement with a health care service contractor, as defined in ORS 750.005,
 29 or a preferred provider organization;

30 (F) A pharmacy benefit manager, as defined in ORS 735.530, or other third party administrator
 31 that pays prescription drug claims;

32 (G) A coordinated care organization, as defined in ORS 414.025; **and**

33 *[(H) A prepaid managed care health services organization, as defined in ORS 414.736; and]*

34 *[(I)]* (H) An accident insurance policy or any other insurance contract providing reimbursement
 35 for the cost of prescription drugs, hospital expenses, health care services and medical expenses,
 36 equipment and supplies.

37 (b) "Step therapy" means a type of drug protocol in which a health care coverage plan will not
 38 cover a prescribed drug unless the patient has first tried a drug or series of drugs specified by the
 39 health care coverage plan.

40 (2) A health care coverage plan that provides prescription drug coverage and that controls
 41 utilization of prescription drugs using step therapy shall provide a clear and convenient process for
 42 a prescribing practitioner to expeditiously obtain an override of the protocol if the prescribing
 43 practitioner demonstrates, based on sound clinical evidence, that the treatment required under the
 44 protocol:

45 (a) Has been ineffective in the treatment of the disease or medical condition of the patient for

1 whom the override is requested;

2 (b) Is reasonably expected to be ineffective based on the known relevant physical or mental
3 characteristics and medical history of the patient and the known characteristics of the drug
4 regimen; or

5 (c) Will cause or is likely to cause an adverse reaction or physical harm to the patient.

6 (3) The duration of step therapy required by a health care coverage plan may not exceed the
7 longer of:

8 (a) The period deemed necessary by the prescribing practitioner to determine the treatment's
9 clinical effectiveness; and

10 (b) A period of 30 days.

11 **SECTION 6.** Section 64, chapter 602, Oregon Laws 2011, as amended by section 70, chapter 602,
12 Oregon Laws 2011, and section 23, chapter 8, Oregon Laws 2012, is amended to read:

13 **Sec. 64.** (1) ORS 414.705 is repealed.

14 (2) Sections 13 and 17, chapter 602, Oregon Laws 2011, are repealed January 2, 2014.

15 (3) ORS 414.610, 414.630, 414.640, 414.736, 414.738, 414.739 and 414.740 are repealed July 1, 2017.

16 (4) Section 14, chapter 602, Oregon Laws 2011, as amended by section 2, **chapter 8, Oregon**
17 **Laws 2012**, [*of this 2012 Act*,] is repealed July 1, 2017.

18 (5) **The amendments to section 2 of this 2014 Act by section 5 of this 2014 Act become**
19 **operative on the date specified in subsection (3) of this section.**

20 **SECTION 7. Section 2 of this 2014 Act applies to health care coverage plan policies, cer-**
21 **tificates or contracts issued, renewed or entered into on or after the effective date of this**
22 **2014 Act.**