

## SB 139 -1, -2 STAFF MEASURE SUMMARY

### Senate Committee On Health Care

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**Meeting Dates:** 2/6, 4/3, 4/8

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#### WHAT THE MEASURE DOES:

Specifies coverage periods for approved prior authorization requests made by health insurers and coordination care organizations (CCOs). Requires CCOs to report biannually to the Department of Consumer and Business Services (DCBS) information on requests for prior authorizations. Prohibits CCOs from requiring step therapy for prescription drug if provider has submitted required documentation indicating inappropriateness of step therapy for particular patient. Requires health insurer to include clinician in same or similar specialty as prescribing provider when considering denial or appeal of denial of exception to insurer's prescription drug formulary. Requires health insurers to report annually on information regarding grievances and appeals and biannually on information regarding requests for prior authorization. Requires an insurer's prior authorization determinations to be binding if claim for reimbursement is a clean claim and enrollee is eligible for coverage at the time the service is provided. Specifies manner and scope of information required to be posted on health insurer's website regarding utilization review.

*REVENUE: No Revenue impact*

*FISCAL: Fiscal impact issued*

#### ISSUES DISCUSSED:

- OMA survey of providers regarding prior authorization concerns
- Utilization of step-therapy and other prior authorization practices
- Insurer PA review process
- Potential impact on health care costs

#### EFFECT OF AMENDMENT:

-1 Establish criteria for insurer use of step therapy. Requires carriers to report prior authorization information to DCBS. Require insurers to include utilization management and step therapy information on their websites.

-2 Establish criteria for insurer use of step therapy. Requires carriers to report prior authorization information to DCBS. Require insurers to include utilization management and step therapy information on their websites. Requires CCOs utilize evidence-based criteria in establishing prior authorization or step therapy protocols. Requires CCOs to report annually to the Oregon Health Authority specified information about prior authorization requests.

#### BACKGROUND:

Through its Division of Financial Regulation, the Department of Consumer and Business Services (DCBS) is the state's primary regulator of all types of insurance companies, including health insurance companies. In 2015, the division regulated health insurers covering approximately 1 million Oregonians in the individual, small group, large group, and associations and trusts markets. An estimated 710,000 Oregonians were covered by self-insured employers, which are regulated by the federal government under the 1974 Employee Retirement Income Security Act (ERISA).

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Coordinated care organizations (CCOs) are networks of physical, behavioral and oral health providers who work together in their local communities to serve people who receive health care coverage through the Oregon Health Plan (OHP), the State's Medicaid program. As of November 2018, 15 CCOs coordinate coverage for nearly 850,000 Oregonians receiving OHP.

Health insurance policies and certificates may include prior authorization requirements that require approval of certain items or services before the insured can receive them.

Senate Bill 139 specifies the length of approval for certain prior authorization approvals and requires health insurers and CCOs to report information on requests for prior authorization to DCBS.