SB 139 A STAFF MEASURE SUMMARY

Senate Committee On Health Care

Action Date:	04/08/19
Action:	Do pass with amendments and requesting referral to Ways and Means. (Printed A-Engrossed.)
Vote:	5-0-0-0
Yeas:	5 - Beyer, Fagan, Knopp, Linthicum, Monnes Anderson
Fiscal:	Fiscal impact issued
Revenue:	No revenue impact
Prepared By:	Brian Nieubuurt, LPRO Analyst
Meeting Dates:	2/6, 4/3, 4/8

WHAT THE MEASURE DOES:

Requires health insurers to approve prescription drug prior authorization requests for a consecutive 12-month period if the use of the drug is based on clinical evidence and the patient continues to be insured during the 12-month period. Requires insurers to establish prior authorization and step therapy protocols that are evidence-based and updated based on new evidence and research. Requires insurers to adjudicate claims based on the approved prior authorization. Allows providers who have requested prior authorization or utilization management exceptions to exercise enrollee's internal appeal and external review rights upon request of the enrollee. Requires agreements between health insurers and third party administrators regarding required grievance, internal appeal, and external review notices to specify the responsibilities of the respective parties. Requires insurers to annually report to the Department of Consumer and Business Services specified information about prior authorization requests received by the insurer. Requires independent review organizations to appoint at least one reviewer who is a clinician in the same or similar specialty as the provider who prescribed the treatment that is under review. Expands period, for which insurers are bound by prior authorization determinations, from determinations made within 30 days to those made within 90 days prior to date of service. Specifies utilization review information that must be provided to contracted providers by insurers. Specifies notice that insurers must give provider when denying a request for service or exception to a step therapy protocol. Specifies timelines for insurers to respond to prior authorization or exemption from step therapy requests. Specifies step therapy protocol requirements. Defines "beneficiary," "clinical review criteria," "medical necessity," and "step therapy."

ISSUES DISCUSSED:

- Oregon Medical Association survey of providers regarding prior authorization concerns
- Utilization of step therapy and other prior authorization practices
- Insurer prior authorization review process
- Potential impact on health care costs
- Work group process

EFFECT OF AMENDMENT:

Replaces the measure.

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, DCBS regulated health insurers covering approximately 1 million Oregonians in the individual, small group, large group, 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).

Health insurance policies and certificates may include prior authorization requirements that require approval of certain items or services before the insured can receive them. Similarly, step therapy protocols are used to help manage costs and risks associated with prescription drugs by requiring initial utilization of the most cost-effective drug and progressing to alternative drugs only if necessary.

Senate Bill 139-A specifies the utilization of prior authorization and step therapy protocols by health insurers regulated by DCBS.